MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
CERTIFICATE OF NEED (CON) COMMISSION MEETING

Tuesday, March 8, 2005
Manty Conference Rooms 1B/1C
Lansing, Michigan

APPROVED TRANSCRIPT

COMMISSION MEMBERS:

Renee Turner-Bailey - Chairperson
Norma Hagenow - Vice-Chairperson
Peter Ajluni, D.O.
Roger G. Andrzejewski
Brad Cory
James Delaney
Dorothy Deremo
Edward Goldman
James Maitland
Michael Sandler, M.D.
Michael Young, D.O.

DEPARTMENT OF ATTORNEY GENERAL STAFF:

Ronald Styka

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH STAFF:

Jan Christensen (arrived 11:38 a.m.)
William J. Hart, Jr.
Larry Horvath
Stan Nash
Brenda Rogers

PUBLIC ATTENDANCE:

Approximately 46 people were in attendance.

(Meeting scheduled to start at 10:00 a.m.; actual start time was 10:10 a.m.)

MS. TURNER-BAILEY: It's 10:10. I'd like to call the meeting to order. If the commissioners would just take a moment to review the agenda? We have a very full agenda today so if you'd like to take a look at it, if you have any suggestions for changes or additions, I will take them now. Otherwise a motion would be in order to accept the agenda as submitted.

MR. GOLDMAN: So moved.

MS. DEREMO: Support.

MS. TURNER-BAILEY: Okay. It's been moved and supported that we accept the agenda. All those in favor, please signify by raising your right hand.

ALL: (Affirmative response)

MS. TURNER-BAILEY: It's unanimous; thank you. Declaration of conflicts of interest.

MS. ROGERS: This is just a reminder for recording purposes. Please identify yourself before you speak. For the last motion, Goldman moved it and was seconded by Deremo. Thank you.

MS. TURNER-BAILEY: Okay. Thank you. Again, declaration of conflicts of interest. Are there any declarations of conflicts?

ALL: (No response)

MS. TURNER-BAILEY: Hearing none, we'll move on to the minutes of the December 14, 2004, meeting. Are there any changes, additions or corrections to the December 14th minutes?

MR. MAITLAND: Maitland's read it word for word and I believe it's correct and I move we approve it as submitted.

MR. DELANEY: Support.

MS. TURNER-BAILEY: Okay. It's been moved by Commissioner Maitland, support by Commissioner Delaney that we approve the minutes as submitted. All those in favor, please signify by raising your right hand.

ALL: (Affirmative response)

MS. TURNER-BAILEY: Opposed?

ALL: (No response)

MS. TURNER-BAILEY: Seeing none, the minutes are approved. The next item on the agenda is entitled Surgical Services, Standard Advisory Committee Charge. Do we have a copy of that, Brenda?

MS. ROGERS: It should be in your binder. It's out of order because of the change of the agenda.

MS. TURNER-BAILEY: Okay. If the commissioners will look behind the tab, Standard Advisory Committee Charge, I wanted to let the commissioners know that upon review of the charge that was originally submitted for the Standard Advisory Committee for surgical services, I realized that we accepted the committee up to saying there was nothing that was done in the Advisory -- or, the work group that could be considered as a part of the work of the Standard Advisory Committee. And I believe that was inadvertent, because we really do want the experts that are gathered as a part of the Standard Advisory Committee to have an opportunity to look at all of the language that was available to review. So I just asked to make what I would consider a relatively small change, which basically took out the language that said that the previous work of the work group could not be considered. And I spoke with Commissioner Hagenow; she agreed with that change. So I thought it was important that I bring it to the Commission and the public that we made that change. So are there any questions?

ALL: (No response)

MS. TURNER-BAILEY: Okay. Thank you. Next on the agenda, CON Review Standards for Hospital Beds. Brenda?

MS. ROGERS: We held the public hearing back in January on the hospital bed standards regarding the limited access areas. And before you today, you have that language in your packet. Along with that language, there are a couple of technical amendments in there, if you've looked at them. I'm not going to review each and every one, but if you have questions, certainly feel free to ask and I'll try to give my best response to that. One of the amendments does deal with Appendix E, so if you want to, just take a quick look at that. And that has to do with the limited access areas. We ran the numbers, did a double-check, I think even a triple check so that's why there's an amendment on Appendix E from when it was submitted to -- for public hearing. And, again, we've also updated the information from Michigan State University. We have received their final report, and that is also included in your packet. And so we've added language into the appendix identifying that

information as well. And one of the other amendments just to note to you, is we are suggesting that we remove the Department inventory from Appendix C. There is a section in there that states that applicants do need to contact the Department for the most current inventory. So I think as you're all well aware, the inventory that's usually listed in the appendix isn't the most current. So our recommendation is just to remove it. The applicants have to contact the Department anyway, so that's our reasoning for that. And we are trying to do that in all of the standards where the Department has to maintain the inventory. So unless you have any other questions, we would, you know, recommend that this be moved forward.

MS. TURNER-BAILEY: Are there any questions?

ALL: (No response)

MS. TURNER-BAILEY: I have one card for public comment, Patrick O'Donovan.

MR. O'DONOVAN: Good morning. My name is Patrick O'Donovan, director of planning for Beaumont Hospitals. Thank you for the opportunity to provide comment on the proposed hospital bed standards. I participated as a member of the Standard Advisory Committee that developed the recommended changes to the hospital bed standards. And I believe these recommendations were based on solid planning criteria that will result in improved access to hospitals and hospital beds. The only part of the proposed standards that Beaumont does not agree with are the comparative review criteria for new limited access area hospitals that are heavily weighted in favor of applicants with higher proportions of uncompensated care Medicaid. Specifically, our concern is that because payer mix represents fully 45 percent of the total points available in the comparative review that any needed hospitals will be awarded based on payer mix, regardless of cost, quality, efficiency, or access considerations. Health planning should be based on the health needs of patients and access to services at reasonable cost. Why should adverse payer mix be a rationale for health planning for the citizens of the state? First, all of the CON review standards recently have been revised to require participation in the Medicaid program. Second, State and Federal policies and laws already compensate hospitals with high percentages of Medicaid and uninsured patients; Medicaid disproportionate share of hospital payments and the quality assurance assessment program are the two most notable. Third, Medicare reimbursement formulas also take into account hospitals' Medicaid involvement resulting in vast variations in Medicare reimbursement to hospitals. This means that for the same inpatient case, Medicare pays a disproportionate share of hospitals more than they pay other hospitals. Because of the factors involved in determining Medicare reimbursement, Medicare is an adverse payer for some hospitals, including Beaumont; yet Medicare is not included in the comparative review criteria, only Medicaid and uncompensated care. CON applications and comparative reviews should be judged based on the applicants' abilities to bring quality care and access to the population to be served at reasonable costs. The proposed comparative review criteria don't reflect that, since 45 percent of the points are awarded based on adverse payer mix. The practical impact of these criteria is that any Detroit- based applicant will be awarded a hospital over virtually any other applicant, regardless of cost, quality, efficiency, or access. Of additional concern, and I would say an even larger concern, is the precedent that this sets. The comparative review workgroup that came up with this proposed criteria is recommending that this criteria be extended to all hospital bed applications that are subject to comparative review. For purposes of final approval of these standards, Beaumont recommends that the point categories relating to payer mix be removed, and the potential points totaling 100 be proportionately redistributed among the remaining categories. Beaumont further recommends that this comparative review issue be revisited as part of the charge of the next the hospital beds Standard Advisory Committee. Thank you.

MS. TURNER: Thank you. Are there any questions?

ALL: No response.

MS. TURNER-BAILEY: I don't have any more cards for public comment. And so therefore, at this point a motion would be in order relative to the hospitals beds proposed language -- standards for hospital beds.

MS. HAGENOW: I move approval of the present standards for hospital beds.

MS. TURNER-BAILEY: With the technical amendments?

MS. HAGENOW: Yes.

MS. TURNER-BAILEY: It's been moved by Commissioner Hagenow that we approve and move forward the standards for hospital beds proposed language with the technical amendments. Is there support?

DR. SANDLER: Support.

MS. TURNER-BAILEY: Support by Commissioner Sandler. Any discussion?

MR. GOLDMAN: I have a question. Let's see if I can -- these are -- we're looking at review standards for hospital beds for final action. Later on the agenda, we have a proposal from the Karmanos Institute for review standards for hospital beds. The standards that we're looking at right now talk about relocation of beds and talk about critical access hospitals. Would a cancer hospital constitute a critical access hospital?

MR. HORVATH: (Shaking head negatively)

MR. GOLDMAN: It would not?

MR. HORVATH: No.

MR. GOLDMAN: Okay. So that under these standards that we're looking at now, a proposed new hospital would have to include emergency services, OB services, surgical services. How will we be able to square these standards with the Karmanos proposal, where they are asking for certain services -- bone marrow transplantations, CT, MRI, Megavolt Radiation Therapy, PET, surgical services, but not 24/7 emergency room or OB services -- are we -- is there a drafting problem that we have to think about here?

MR. HORVATH: Yeah. The proposal for Karmanos -- I don't want to get too far ahead of them, but it will be under the LTAC language. And the LTAC language prohibits long-term acute care hospitals from having any other services. So this will -- the Karmanos language would be proposed under a different subsection, so we do not believe there is any conflict.

MR. GOLDMAN; Okay. So that we can approve these standards for hospital beds without getting crosswise with any standards that we'll consider later today because they are under a different subject -- a limited subject; correct?

MR. HORVATH: (Nodding head in affirmative)

MR. GOLDMAN: Thank you.

MS. TURNER-BAILEY: Any other questions?

ALL: (No response)

MS. TURNER-BAILEY: Any further discussion?

ALL: (No response)

MS. TURNER-BAILEY: All those in favor of the motion, please signify by raising your right hand.

ALL: (Affirmative response)

MS. TURNER-BAILEY: Opposed?

ALL: (No response)

MS. TURNER: It's unanimous. I'm tempted to thank those who have worked on the Standard Advisory Committee for hospital beds, but I deeply suspect your work is not complete. But certainly your efforts so far have been greatly appreciated by myself and by the Commission. I'll take the liberty of speaking for the Commission at this point. Thank you very much. Yes; Commissioner Hagenow?

MS. HAGENOW: I'd just like to have the follow-up in terms of from the Department as to the focus of what we said the Department -- the University needs to do next. I think in the time that's gone on, this settled the issue of geographic and time to get to acute care hospital beds. But we had left over issues. And I was wondering if there could be a summary of that so we would probably all have the same recollection, if it's appropriate at this time, because there's a follow up on this.

MR. HART: The intent of the Department is to continue with the relationship with M.S.U. We have a meeting set up in the next couple of weeks with the Department of Geography to go over the next steps, what needs to continue there. We haven't consummated that relationship because we were contracted with them for a specific task and it is now over. So the suggestion that additional things move forward, we'll need to sit down with them and see if they can help us out on that, or how that's going to go. We haven't articulated exactly what needs to be done. That's an excellent question and we need to meet with them and meet with, perhaps, some of the folks that met with us earlier on the SAC to say, okay, what needed to move forward and can we lock that in. That is our intent. But it has not been done yet.

MS. HAGENOW: Because the way I understood it in the simplest form is that we proved that somebody can get to a hospital, but not necessarily what the capacity of that hospital is or that it is meeting the needs of the density of the population within that particular area. So there were leftover things that were hanging out there. I thought it was a giant step forward, but I just don't want us to sort of say, "Okay, we're all done with that," because I think there is some refinement that really needs to be done. And we probably need to put that together and maybe some of the members of the team could be helpful on that; that were --

MR. HORVATH: The follow-up on that is the presentation from M.S.U. at the last Commission meeting or maybe two Commission meetings said that that additional factor, as you stated, is basically what has been done today is to assure that there is a hospital bed within, I believe it's 30 minutes, a hospital bed that is in a hospital that has 24/7 emergency care. It does not address the density issue. M.S.U. said that they would not be available to work with the Department until the summer months. And so what we were planning to do is we'll start to get that process going in advance of the next SAC for hospitals beds, so that way -- because one of the problems with the last SAC was a lot of times they were waiting on M.S.U. and -- to complete their work so they could complete -- so we're trying to get that step. As soon as M.S.U. is ready and available to start to address that next analysis, we will move forward on it.

MS. TURNER-BAILEY: Commissioner Andrzejewski?

MR. ANDRZEJEWSKI: If I may make a recommendation, I'd like to see the researchers from Michigan State convert their findings into layman term. Sometimes it takes a researcher to understand what another researcher is saying. And I think they could do a better job with that.

MS. TURNER-BAILEY: Good point. I hope the Department will take note of that and pass it along. Thank you. Our next agenda item, CON Review Standards for Psychiatric Beds and Services, Occupancy Rate. Brenda?

MS. ROGERS: Again, the public hearing for the psychiatric beds was held back in January. The main issue with the standards was to change the occupancy rate for the planning area from 90 percent down to 85 percent. Again, along with that, we've gone through and tried to do some more clean up. There is no longer a, quote, "Department of Mental Health." That was merged into the Department of Community Health. So that's what the majority of these technical changes are. There are some things in there that just no longer exist. Again, we are recommending that the Department inventory -- for the same reasons as mentioned previously for the hospital SAC bed standards -- be removed from these standards as well, because again, the applicants do need to contact the Department for the most current data. And then there are a couple of other -- there's a couple of them that were noted in here as possible technical amendments. And those specifically were items under Section 21(gg), the definition of psychologists, and then under Section 7(d); again, it

identifies the Department of Mental Health administrative rules. We've done some checking on that and we're not going to recommend an amendment on those two items at this point in time. There are some further issues -- technical issues that we will be sitting down with the individuals within the Mental Health Division because there are still some other clean-up issues in these standards that need to be taken care of. But we feel those can be taken care of in the next go- around of changes to the site standards. So if you have any questions?

MS. TURNER-BAILEY: Thank you. Any questions? Commissioner Sandler?

DR. SANDLER: Unfortunately this was very late in the day at a long meeting last time, so I understand if some of the commissioners had to leave. Dr. Creelman, who is the president of the Michigan Psychiatric Association was the physician from Pine Rest who spoke to this and basically said that they cannot hospitalize some patients because invariably when they have an opening it's a two-bed room and it's the wrong sex. This was a relatively minor adjustment. It would make most of the beds, 12 out of 17, would only affect this one institution, which does a lot of psychiatric inpatient of west Michigan, Grand Rapids. This was strongly supported by -- I'm not putting words in Lodi's mouth, but was strongly supported by the Alliance for Health. The minutes should note that. Mr. Zwarensteyn is nodding his head in agreement. And this hospital had given up beds voluntarily in the past. And putting that all together, the six commissioners that were there did vote six to nothing to send this to public comment as a reasonable -- this will only change, I think, 17 beds in the state, as I recall, to begin with. Thank you.

MS. TURNER-BAILEY: Any other questions or comments?

ALL: (No response)

MS. TURNER-BAILEY: I don't have any cards for public comment for this particular agenda item. And so in light of that, a motion will be in order.

DR. SANDLER: I move that we approve this with the technical amendments as presented to us, please.

DR. AJLUNI: Support.

MS. TURNER-BAILEY: It's been moved by Commissioner Sandler, support by Commissioner Ajluni, that we accept the language -- move the language forward with the technical changes -- I added that to your motion.

DR. SANDLER: Thank you.

MS. TURNER-BAILEY: Any discussion?

ALL: (No response)

MS. TURNER-BAILEY: Hearing none, all those in favor, please signify by raising your right hand.

ALL: (Affirmative response)

MS. TURNER-BAILEY: Opposed?

ALL: (No response)

MS. TURNER-BAILEY: It's unanimous. Next on the agenda, we do have a presentation from the Hillsdale Community Center. Are you prepared for your presentation?

MS. LOWES: Yes.

MS. TURNER-BAILEY: Okay.

MS. LOWES: I'm going to try to keep this brief. Good morning, my name is Joan Lowes, I'm an attorney with Hall, Render, Killian, Heath & Lyman, representing Hillsdale Community Health Center. At your last meeting, you heard compelling testimony from a citizen and a social worker from Hillsdale about the problems that community faces in securing needed psychiatric services for its residents. In brief, patients often wait for long periods before they can be moved many miles for inpatient psychiatric care. After discharge, these patients and their families must travel long distances for outpatient follow-up treatment. There are no psychiatrists in Hillsdale County, and the hospital cannot attract these specialists without inpatient beds. Under the current standards, an application for psychiatric beds will generally not be approved if the number of beds proposed in the application will exceed the needed bed supply. This rule effectively precludes the initiation of psychiatric services, even where bed need is shown to exist in the particular planning area. To remedy this inequity, the suggested language you have before you in Section 6(f) of the standards would allow an applicant to request and be approved for up to a maximum of 20 beds, if the bed need in the planning area is equal to or more than one or less than 20. Similar language exists today in the nursing home standards. The applicant would still have to meet all of the other requirements in the standard. The occupancy rate standard, however, in 6(d) would apply only to applicants proposing an increase in existing licensed bed capacity. There is -- excuse me --

MR. HORVATH: I hate to interrupt. Just for the commissioners to follow along, it's under your Correspondence tab. The proposed language is -- will be under the Correspondence tab.

MS. LOWES: Thank you. Do we need to go back and --

MR. HORVATH: Why don't you?

MS. LOWES: -- review that again? This -- it's important that you find the language in 6(d) -- or, excuse me -- 6(f).

MR. HORVATH: It should be -- under Correspondence tab, it should be your first insert, page 8.

MS. LOWES: I did just put out extra copies for the audience. I didn't want to get you confused with the language that was just under consideration for the occupancy rate.

MR. HORVATH: You will see -- on page 8, you will see underlined words in 6(d) and (f). And if you're looking at a copy that has underlined words in the language, then that is what Joan is going to be speaking to.

MS. LOWES: Does everyone have that?

MS. TURNER-BAILEY: Yes; thank you.

MS. LOWES: Okay. Let me backtrack for a second, then. Under the rule as currently configured, it effectively precludes the initiation of psychiatric services, even where bed need is shown to exist in a particular planning area. To remedy this iniquity, the suggested language you have before you in 6(f) would allow an applicant to request and be approved for up to a maximum of 20 beds, if the bed need in the planning area is equal to or more than 1 or less than 20. Similar language exists today in the nursing home standards. The applicant would still have to meet all of the other requirements in the standard. The occupancy rate provision, however, in 6(d), would apply only to applicants proposing an increase in existing licensed bed capacity. This is because there is little justification for allowing an increase in beds at an existing facility that does not conform to the occupancy rate standard. This small change has the support of the Hillsdale community and the hospital board. It will allow Hillsdale and other hospitals who might be in like circumstances to provide needed psychiatric services in their communities. I'd be happy to address any questions the Commission may have.

MS. TURNER: Are there any questions? Commissioner Hagenow?

MS. HAGENOW: I guess in simple language, what you're saying is you approve of what we just approved? Is that not right?

MS. LOWES: Yes.

MS. HAGENOW: Because that's what we just now approved, is it not?

MS. LOWES: No.

MR. HORVATH: It's different. Right now -- the standards that were just approved basically lowers the occupancy threshold that you must achieve to 80 -- 85 percent. This adds a caveat onto that, that says if you're a brand new -- if you're applying to be a new institution in the planning area, you don't have to demonstrate existing capacity as achieving 85 percent. However, if you're an existing facility seeking additional beds, you do have to prove that 85 percent.

MS. HAGENOW: So 6(f) -- I mean, on page 8, the (f) in particular, and even though I heard what you said, I was thinking that we were approving this in this form. But we're not; we're approving only the 6(d)?

MS. LOWES: We would like you to approve it in this form also.

MS. DEREMO: This is an addition.

MS. LOWES: This is an addition. But we are certainly requesting that you approve it.

MR. HORVATH: So, to be a little bit confusing, what would happen is the language you just passed today, once it takes effect, this language will then be modified to show the 85 percent. But because that language has not taken effect because you just passed it, we had to leave the 90 percent language in there because that is still current standards. But once the legislature and the Governor does -- does not -- takes no negative action, the 85 percent would automatically be reduced in this proposed language that Joan is offering today.

MS. TURNER-BAILEY: So this is an immediate modification of what we just passed is what you're saying?

MS. LOWES: Correct.

MR. HORVATH: I mean, this is what --

MS. LOWES: An additional modification.

MR. HORVATH: -- Joan is asking for.

MS. HAGENOW: That's what she's asking for?

MS. LOWES: Correct.

MR. MAITLAND: Did this go out for public hearing and was discussed?

MS. ROGERS: Not yet.

MR. HORVATH: The only thing that went out for public hearing was the 85 percent. If this was -- if the Commission took action on this today, this would have to go out for public hearing. So psych standards, in effect, would be updated twice within the year because you will -- in 45 days or thereabouts, the 85-percent rule with take affect. And if this moves through it's natural course of a public hearing and then final action, then these changes would also take effect. So in a sense, there would be two revisions to the standards. But they, in a sense, stand alone.

MR. MAITLAND: Does the Department support this change?

MR. HART: After the last meeting in December when this issue came up we sat down with these folks to talk through this issue with them. And the language that's in here is supported by the Department and brought to the -- although not brought to this Commission by the Department, the Department has worked with these

folks and we can support this language. It would be up to the Commission, of course, to decide if they wanted to move forward to public comment, et cetera, et cetera.

MS. TURNER-BAILEY: And just -- I'll call on you in one second, Commissioner Hagenow -- I just wanted to point out you may notice on the agenda, it says, "Commission action," it doesn't say "Commission proposed action." So that gives the Commission, really, the freedom to do whatever you want to, from choosing to move the language forward to public comment, to taking a little bit more time to consider the language and maybe bringing it up at the next Commission meeting, et cetera. I'm just giving you sort of the -- we can do whatever we want, in other words. We're not tied to proposed action on this item. Commissioner Hagenow?

MS. HAGENOW: My -- I guess I'm still trying to really understand what the addition is, in terms of 1 bed to 20 beds; as long as it's subtracted from the overall beds?

MS. LOWES: Correct.

MS. HAGENOW: So a hospital, like Hillsdale, is going to decide that they have a psychiatric need in the community and they can decide anywhere from 1 to 20?

MS. LOWES: Well, the problem is that if bed inventory is 1 or 2, the hospital is not going to be able to initiate psychiatric services. This would effectively allow the initiation of services in that window where the needed bed supply is between 1 and 20. Otherwise, nobody is going to initiate psychiatric services, because the bed supply is never going to jump huge amounts.

MR. HORVATH: If I could add to that, currently there is a provision in the standards already in effect that says a psych unit to be initiated must be 20 beds. However, the Department does have the authority to waive this. That is similar to the nursing homes. And that's why in the nursing home standards, we have the 1 to 20. If there's one bed available in the inventory, or five beds available in the inventory, the applicant has the right to request up to 20.

MS. TURNER-BAILEY: Commissioner Sandler?

DR. SANDLER: This was, again, right at the end of a very lengthy meeting last time.

MS. LOWES: How well I remember.

DR. SANDLER: And there was compelling testimony, as Joan says, from people from Hillsdale. There are letters that I'm certain you've all read from the sheriff, from the chief of police, about the difficulties that law enforcement has covering for these people. It's both a patient safety and frankly a public safety issue to have a small psychiatric facility. I believe the case has been made. The prejudice is here, that is that rural hospitals perhaps need slightly different standards or a few things that the City of Detroit -- metropolitan Detroit -- doesn't need. And therefore I would like the Commission to move what has been presented to a public meeting -- public hearing.

MS. DEREMO: I support that motion.

MS. TURNER-BAILEY: Was that a motion?

DR. SANDLER: Yes.

MS. TURNER-BAILEY: I'm sorry. It's been moved by Commissioner Sandler that we move the language that has been suggested by Hillsdale to public comment and has been supported by Commissioner Deremo. Are there any questions or is there any discussion?

ALL: (No response)

MS. TURNER-BAILEY: All those in favor, please signify by raising your right hand.

ALL: (Affirmative response)

MS. TURNER-BAILEY: Opposed?

ALL: (No response)

MS. TURNER-BAILEY: No opposition. Thank you.

MS. LOWES: Thank you.

MR. HORVATH: On an added note, we would like to bring something to the commissioners' attention on this language.

MS. TURNER-BAILEY: It's not going to affect our vote we just took, is it?

MR. HORVATH: Well, no. I mean, in a sense, this has been discussed -- this was discussed in Joan's presentation. I think Joan's been here twice on this presentation. Under the standards, the Commission can charge the Department with updating the inventory. By charging the Department to rerun the inventory, that does not require a public hearing and does not require to go before the Governor or the legislature. Currently -- we think this goes in tandem with the language, but it is not an absolute because you -- we could do this, what we're going to be asking, with or without the language. But the Commission is supposed to be taking a look at the bed inventory at least every seven years. The Department is supposed to bringing it to the Commission's attention every -- at least seven years. So this is our obligation to bring that the current inventory has not been updated in many years and we would ask that the Commission charge the Department with doing its final analysis of running the inventory. If we run the inventory -- this is a preliminary run. If we rerun the inventory, a couple of things: On the first page you will see the adult inpatient psychiatric beds. You'll see the first column is all the planning areas in the state. The second column includes all of the counties in the planning area. The Department inventory means currently -- for instance, we're just going to take one example; Detroit/Wayne planning area. Currently there are 516 psychiatric beds approved in that planning area by the Department and up for licensing. The current bed need is 717. That means there is a current need in the Detroit/Wayne planning area of 201, based on 2003 data. Because the 2004 data is not yet released and available to the Department, we ran our analysis on 2003 data. That would make the Detroit planning area a bed need of 420. You will go from a beds need of 201 to a beds surplus of 96. So we do want to make sure that the -- in our preliminary analysis that you understand what we will be doing. So we will be rerunning either with 2003 or 2004 data. Depending on if the Commission charges us to do that today, we would bring our final analysis back to the Commission for the June meeting. And then if you approve it and decide that you want to have it take effect, then you will determine what date it will take effect in the future. If you take a look at this list, in addition to running the numbers, though, we also needed to take a look at the planning areas in the state. And the planning areas are based upon the mental health authorities. And those have changed since the last rerunning. So what we have done in our preliminary analysis is we have bolded those. At one point in time -- and the current inventory, for example, Lake, Mason, and Oceana are individual planning areas. If we update the inventory, they are now one planning area. So that's why you will see that West Michigan planning area bolded. Currently there are 14 licensed beds between the three planning areas but there -- I didn't put a bed need in there because they're individual. However, if we did update the planning areas along with the bed inventory rerun, it would have a bed need of 15, meaning that there would be a need of 1 bed in that planning area. So if we move on Joan's language, that would mean that because there is a bed need of one, somebody could come in and submit an application up to 20 beds. Okay? Now, if you take --

MS. TURNER-BAILEY: Someone besides Hillsdale, you're saying?

MR. HORVATH: It would have to be in that planning area. Now, if you take a look at the third page, this is a child/adolescent preliminary run. The child/adolescent run basically -- there is a provision in the standards and the Department will be doing a review of all the standards to make sure we are fulfilling our obligation to the Commission. But there's a provision in the standards that says that we should be bringing to the Commission every two years the child/adolescent use rate. That has not been done in the past. But we will start to -- we will add that to our list of things that we need to do on a routine basis. The current use rate is set at 50; that's

in the appendix of the standards. If we take the 217 If we take the 2003 use rate to recalculate this, it goes down to 18. So, again, taking planning area HSA 1 -- the current inventory is 171 child/adolescent beds in the HSA 1. Current bed need is 217. That means there's a need of 46 beds. However, when we calculated under the 18 use rate, the revised bed need will be 82, meaning there will be a surplus of 89 beds in that planning area. And if you take a look at the last page, we tried to show you what the current adult planning areas are and what the new, proposed planning areas would be if the Department was to rerun this. So what we are asking today is if the Commission would like to charge the Department with doing a final run using current data to rerun the psychiatric bed need numbers in addition to updating the planning areas to correspond with the current mental health authorities as existing in the state.

MS. TURNER-BAILEY: Any questions? Commissioner Goldman?

MR. GOLDMAN: Do you know when the 2004 data will be available?

MR. HORVATH: Not at this point in time. The 2003 was released in April last year.

MS. ROGERS: My understanding is that the 2003 was released in April of 2004 so they are expecting that the 2004 should be released, you know, about the same time this year. So it should be shortly, but we just don't have an exact date.

MR. GOLDMAN: So if we were to charge you with revising this using the most current data you have available, that gives you the option to use the 2004 data should it become available in the process, rather than mandating 2004 just in case it's not available?

MR. HORVATH: Correct. What we would try to do is -- because if you charged us to bring it back to the June meeting, that would give us all the way -- obviously trying to get it to the Commission in advance to review, but we would work with the State demographer's office that, you know, if it's going to be released several weeks prior to this June, we would use the 2004. But if it's not released in time for the Commission, then we would proceed to calculate based on the 2003, which would just be a rerunning of our numbers to make sure we did it right on the 2003.

MR. GOLDMAN: And under the 2003 numbers, if I'm looking at this correctly, if we were to pass the language requested by Hillsdale and if you were to rerun the numbers there would be a 1 bed surplus which would allow, under this language, for them to apply for a psychiatric unit?

MR. HORVATH: It would allow them and others; correct.

MR. GOLDMAN: It would allow anyone in the --

MR. HORVATH: -- in the planning area.

MS. TURNER-BAILEY: Any other questions?

ALL: (No response)

MS. TURNER-BAILEY: Well, I have a question about available -- when the data might be available. Commissioner Goldman was saying if we say use the most recent data, does that mean if that happens to become available before the next Commission meeting? Or --

MR. GOLDMAN: Yeah; it would be, "Give us a report in June using the most current available data."

MS. TURNER-BAILEY: Okay. So if it happens to come available, you know, a week before the June meeting, we would expect for them to use the 2004 data? I'm just trying to -- you haven't made a motion. I'm just trying to understand.

MR. GOLDMAN: So long as it is reasonably appropriate or --

MS. TURNER-BAILEY: Okay.

MR. HORVATH: We could -- if it's not released, if we -- what we will do is, if the Commission wants, we will provide our analysis with your packets with the most current data if available. If not, then we will come to the Commission with a statement from the State demographer, are we a week away? Are we in June? July? August? But we could follow up on that. We would do our best. I mean, Stan's schedule is pretty tight, but he's pretty good on running this number so that it shouldn't take us too long if we get it, that we can fulfill that obligation.

MS. TURNER-BAILEY: Okay. Commissioner Hagenow?

MS. HAGENOW: Just an understanding that changes that you put out here, it just seems like there's such a decrease in psychiatric beds. And it's not my sense that the population's getting much healthier mentally. I'm trying to figure this out. So you use the same criteria?

MR. HORVATH: Yeah. But if you take a look -- I think in Joan's last presentation or the one before, she actually worked with Alex Dukay in the Licensing Bureau. And the occupancy rate statewide is 60 percent for our facilities.

MS. HAGENOW: Interesting, because just anecdotally and intuitively, that doesn't seem to be the -- but I guess maybe it's institutionally. So it's a change that I find curious, but it doesn't change the fact that it's important to update it.

MR. HORVATH: As we are working with the Mental Health side of the Department on the technical changes to update the rules -- or the references to the rules and law -- Mental Health Code, we will also be sharing them -- our calculations -- to make sure we did everything. One thing is the standards say that the use rate for adolescents should be shared with the Commission every two years. Well, that hasn't been done. We haven't done that. We are trying to develop a list of everything we need to share with you. But that use rate should -- would have been going down gradually. Because we haven't done that, we are going to see a dramatic one-step correction.

MS. TURNER-BAILEY: Are there any other questions? Commissioner Maitland?

MR. MAITLAND: I move that we charge the Department with updating the psychiatric bed count needs with the most available information -- most recent available.

MR. DELANEY: Support.

MS. TURNER-BAILEY: Okay. It's been moved that we charge the Department with updating the psychiatric bed numbers and supported by Commissioner Delaney. Any discussion?

ALL: (No response)

MS. TURNER-BAILEY: All those in favor, please signify by raising your right hand.

ALL: (Affirmative response)

MS. TURNER-BAILEY: Opposed?

ALL: (No response)

MS. TURNER-BAILEY: It's unanimous. Okay. So you have that charge now. We'll look forward to the numbers at the June meeting. Rural MRI services, MHA. Amy Barkholz?

MS. ROGERS: You'll find that information in your packet also under "Correspondence." It should be immediately following the psychiatric language.

MS. BARKHOLZ: Hi; good morning. I'm Amy Barkholz from the Michigan Health and Hospital Association. And for the folks in the peanut gallery, I also did put copies of the proposed language in the back. I think they were later than you all arrived. So I know what it's like to sit back there and not have the language in front of you. I really hope that we can keep the continuous support voting record going on. That's really what I hope for. I want to explain just briefly the situation with the rural MRI language. I know you all received some correspondence from me at an earlier point. Really what we're talking about here is a problem and perhaps a mistake. It's not a mistake of the Department's; I don't think it was a mistake of the hospitals. I guess I could take the blame. But it's one of those things that we just did not catch. When we came to you about six months ago -- a year ago, really, starting the process to talk about the need to adjust the MRI standards to allow rural hospitals -- hospitals in counties that don't have any fixed MRI service -- some adjustment so that these people can get fixed MRIs. We talked about who we thought would qualify for that, based on the volume numbers, based on being in a county that doesn't have any other hospitals with fixed MRIs. And we gave you a list of hospitals so you could get an idea of how many people and how many facilities, really, we were talking about. In all of that discussion, we had included a couple of -- two hospitals in particular who we thought qualified for this fixed MRI under the new provisions that you helped put into place this summer. One is Pennock Hospital in Hastings, and the other is Branch Community Hospital in Coldwater, both in small rural-type communities. The problem that we discovered mid-November was the Federal census has reclassified Barry County, along with three other counties in Michigan. There are four counties total who, because of the way the census now looks at them, they don't consider rural anymore. I thought that that meant they were micropolitan, and we fixed that problem. But they aren't micropolitan, they're actually urban because they are close enough to larger urban areas that they're considered to be in those commuter routes. The impact that had on the rural MRI provisions and Pennock Hospital and Community Hospital of Branch County is they -- they thought that they qualified for the fixed MRI. And they -- to confirm that they had the volume numbers, they went online to the State's website, which is great. The State calculates the volume. And it's important to rely on that because we have a lot of various adjustments in MRI procedures, so you just can't count the actual number of procedures you do a year because that gets adjusted based on how severe those cases are; whether they're children, whether they're adults; whether you're in rural areas or micropolitan areas or whether you're in urban areas. So just counting your numbers doesn't tell you anything. You go onto the site, it adjusts them for you, and then you see how many you have. When the two hospitals did that continually, it showed that they had over the volume numbers to get a fixed MRI. So they did all the legwork necessary in their communities to get approval, to seek bids, to make sure they had staff, et cetera, and then they sought the CON application approval. And then on November -- mid-November, about November 1st, the State updated those numbers. Nobody did fewer procedures. Their adjustments in terms of severity didn't really even change. What changed was that Barry County no longer is rural. And what that meant is they never -- they didn't get the adjustment factors that they thought they were getting, and geared up to get. In addition, Branch County, which is still rural, was sort of the collateral damage to this because they shared a mobile route with Pennock Hospital in Barry County. And one of the adjustment factors is if all of your mobile route sites are rural, you've got an adjustment factor. This came as a huge surprise and was obviously devastating news to these two facilities because they were on the cusp of moving forward with their fixed MRI. We approached the Department about this issue. They were great. They worked with us to try and figure out and explain what was really going on. But ultimately they said, you know, the rules are the rules and we don't make them, the Commission does. And you really need to take this to them to seek a solution. Well, what we decided in terms of a solution that would be narrow enough to hopefully get your approval to move forward today, not negatively or positively impact other people who didn't already put the time and effort into getting a fixed MRI under the language that you passed this summer, is to look at going into the existing MRI standards. And where you give adjustment factors, currently for rural areas and currently for micropolitan areas, we are seeking to temporarily add another adjust- -- add another category of folks that would get those adjustment factors. And that other category is, until the end of the year if a county was rural under the 1990 census, they would also qualify for the adjustment factor. It is not making them rural again. It is not making them micropolitan again. It is simply saying that for the set period of time because of their reliance on the published data, they were rural in 1990 and they would qualify for these adjustment factors. The reality is this would mean two hospitals that you already presumed would be getting a fixed MRI would be able to follow through with their application process and get a fixed MRI. We talked to the Department about this, and I'll let them speak for themselves. They've been very helpful in recognizing and trying to seek a solution for these two hospitals to move forward with their application. The one concern that I've heard them express, which I think is valid and I wanted to address with you is there are other standards that also give adjustment factors for rural areas or micropolitan areas. If we make this change in these standards, will you be coming to us on these

other standards and asking for the same thing. And my response to that is, there are four counties -- Cass, Newaygo, Barry and Ionia County -- who are no longer micropolitan or rural. They are metropolitan. They are going to have issues in all of the other standards potentially where rural adjustment factors are given. What they will not be seeking is a quick fix like this MRI situation. We think this fix is warranted because there was reliance and notice given to everyone, the public and you all. What we do think we can engage in a dialogue about, in a slower and more open process, would be are these four counties something different than the Federal census classifies them as? And maybe we can have that process go forward at some later time. So I guess what I'm saying to the Department and to you all is no; we will not be seeking similar language in subsequent standards to address these four counties. Two of the counties are sitting in the audience right here, and listening to it. The other two counties, Newaygo County with Gerber Memorial Hospital and Cass County, with Borgess-Lee, who has a Borgess representative, have also been part of this discussion. They're not seeking to insinuate a quick fix. They would like to talk at a later time about, you know, how much population they really have in their counties and how small their communities are. But they're not going to be seeking a fix in other standards. What we really want to do is allow the two hospitals that were geared up to move forward with their fixed MRI to move quickly. And so what we would ask is if you could take -- if you could approve the proposed language that we've distributed out here, send it to public comment, we'll gather more input as we go along, and hopefully take final action at your June meeting. This would allow them to move forward in a time frame that would be workable for them. I have contacted a lot of folks that helped and supported the rural MRI provisions: The Economic Alliance, folks from Spectrum who will be putting in a letter of support today, members of the legislature, Representative Caswell, who most of you spoke to earlier this morning, are very supportive of the earlier language. They continue to be supportive. The Economic Alliance, I don't speak for. I know that they -- they're staying out of this discussion. But we do want to engage everybody who was part of this before. And at this point the feedback has not been we don't support these two hospitals getting a fixed MRI, it's how can we move forward in a narrow way and fix this quickly? And that's what I think this language will do.

MS. TURNER-BAILEY: Thank you. Are there any questions? Commissioner Andrzejewski?

MR. ANDRZEJEWSKI: Did the application for a fixed MRI precede the reclassification of the territory?

MS. BARKHOLZ: Yes, in some instances. What happened was in the case of Branch County -- and the CEO, Randy, is here and he'll talk for himself -- they submitted their letter of intent, and they were in the process of gathering all the materials for their application when the change went into effect in November. So they were in the situation where they got a call from the Department saying you no longer qualify because of the reworking of these numbers. In the case of Pennock Hospital, they were actually calling to find out how to submit their letter of intent. They did submit their letter of intent. And they can follow up if they want to say a word or two. So, you know, it wasn't a matter of finding out before they've gone down the road. I mean, they first had to meet with their Boards of Trustees, their staff, you know, do due diligence which is required under the rural MRI provisions to make sure that they could -- their communities could support these fixed MRIs before they initiated a CON process. That had all been completed; you know, the expenses had been accounted for and the letters of intent, at least, had been filed when the change was made.

MS. TURNER-BAILEY: Commissioner Sandler?

DR. SANDLER: Just for a historical background of how we got here, there was movement and a case made that rural hospitals, of which there are eight, who had more than 4,000 procedures -- 6,000 needed for a fixed -- they had between 4,- and 6,000; Sault Ste. Marie, Hillsdale -- there's a group of them -- Ludington, because of problems of traveling and the isolation of rural hospitals -- there was a work group -- I was liaison commissioner, the Economic Alliance for Hospitals, we all met. And we came to a consensus statement as to an appropriateness that would affect only those eight. That's eight machines out of about 160 of them at that time, including the ones in the pipeline. Larry Horowitz and Barbara -- Barbara was at the meeting -- we went back and they discussed with their health counsel who chose to approve this as well. Everybody agreed with this, at which point, just when we were going to pass this, the Department -- not the Commissioner, not the Economic Alliance -- came up with -- they didn't like the 25 miles. There was a question of using Mapquest; "as the crow flies"; there was all this detail. And they came up with the suggestion, no; it actually should be 15 miles would make more reasonable -- more reasonable data with this. The data allowed four more hospitals to join the eight, which was not part of the original agreement. It might have been within the spirit of the original

agreement. All the stakeholders, however, agreed with the Department it was appropriate. The Commission then voted unanimously to accept this change from 8 machines to 12 machines; in other words, from eight hospitals to 12 hospitals. That was last year sometime. The two hospitals you're talking about were two out of the four that were added; correct.

MS. BARKHOLZ: One of them was; yeah.

MR. SANDLER: What about the other one?

MS. BARKHOLZ: They were part of the original eight.

DR. SANDLER: Okay. So one came from the original eight, one came from the four. This would be within the spirit of fixing problems in rural health care with the same 12 we actually had approved last year. To put it in perspective, these are not two new ones that came along. We're not going from 12 to 14. It's still only the 12.

MS. TURNER-BAILEY: That's helpful information. Thank you. Any other questions or comments? Commissioner Andrzejewski?

MR. ANDRZEJEWSKI: They had every reason to believe this would be a routine approval?

MS. BARKHOLZ: Yes.

DR. SANDLER: Yes; that would be correct, Roger.

MS. TURNER-BAILEY: Commissioner Young?

DR. YOUNG: I would just be concerned, what does the Department think about the new proposal?

MR. HART: We've worked with the -- looked at the language and asked the Attorney General to take a look at whether or not there's going to be a legal problem with this language, especially given the point that Amy was driving at about cross-fertilizing the rest of the standards; as to, if you made a, quote, "exception" here, what about here, what about here, what about here? Notwithstanding the assurances Ms. Barkholz has offered here, it's still problematic for the Department. We'd like to -- we surely would work with -- we understand the problem. And as Dr. Sandler pointed out, we're in support of trying to come up with an answer for here. The earth moved and metropolitan became micropolitan became rural; all that mumbo-jumbo was out there. And these folks got swept up in that. We'd like to be able to come up with some way of doing that. But we want to be sure that whatever language would be proposed would stand the test. It's definitely an exception. We'd like to continue working with the participants in MHA to see if we could come up with language that would make some sense. If this goes to public comment, that would be an opportunity to do that.

MS. BARKHOLZ: Can I just add something? I talked just recently with Bill about this and I totally respect that comments. And they have been great in working with us and the hospitals to try to seek a way to do it. I guess with all due respect, we make changes in standards that apply to only those standards all of the time. And I understand the argument of not setting a precedent in other standards. But in terms of a legal issue, we have standards that are different from other standards and what they -- factors they allow and for what reasons. So I don't see that as any kind of problem. And I think that the proposed language would clearly address the issue of these two hospitals. And I'm totally willing to do what Bill suggests if the group wants to put it to public comment and there's a specific recommendation we can work out from the Department that does a better job of it within the spirit of this language and would be considered something technical. I also am giving our word as to the four counties that are affected, that we are not going to rush out and seek the same technical amendment on other standards; that we will raise the issue, but we'll raise it in the spirit of a broad dialogue about whether four counties that got reclassified are more like rural and micro counties. But that would not be to seek some sort of quick fix. I think that a quick fix is justified in here because there was a great deal of reliance and the situation was changed mid-stream, as we discussed. I don't think anybody can make that argument about surgical services or other things because we're all on notice here, everybody's standing here that these four counties are -- their situation has changed. So they all know that. So I guess I understand completely what the Department's worried about and respect it because, you know, we don't want

-- we want to have the integrity of the CON standards. But I think it's not a legal problem, I think it's a philosophical issue. And that can be addressed through a public statement that the hospitals that are affected are not going seek that quick fix. We're only talking about four hospitals. So I guess that, in my opinion, helps address it. And that's why I think the folks that are going to come up behind me and talk, will talk about really -- you know, now they have folks on the line. They have hired staff. They have made Board resolutions. They relied on the standards as they were written and the data that was posted. And that data changed and they didn't get warning. That wasn't the Department's responsibility to warm them. They should have known that their county changed. You know, you could argue that I should have known or Randy should know that any other county in the state may affect volume number. But the reality is, these are pretty complex and we didn't realize that. And so this has happened and we are seeking a fix for these two -- these two folks that have relied on it. We are not seeking to change the standards in a broad way to, you know, change the rural status or the micro- and metropolitan of four counties.

MR. HORVATH: If I --

MS. TURNER-BAILEY: Okay. Larry you go and then Commissioner Andrzejewski.

MR. HORVATH: I just want to make a clarification on the process to make sure we're clear on this. One is, a letter of intent is not an application. And the standards are clear in the MRI standards that says you will use the list that is published by the Department that is current at the time your application is submitted to the Department. It's not when your letter of intent is filed with the Department, it's when the application is submitted with the Department. If an application was submitted with the Department in June or July of 2004, all the way up to November, the republishing of the list, the applicants would have been beneficiaries of the greater weight. Because an application was not submitted and the Department was obligated when it republished the list to use the new factors, that any application submitted after November 1st must use that published list. So, again, I want to make sure that we're clear that it is an application that is submitted that you use the list against. Also, I should also make clear that the administrative rules say that it's the standards that are in effect at the time the director issues the final decision. So, for instance, if I'm an applicant, and I'm in the process of having my application processed and the Commission passes and the legislature and the Governor do not reject and the standards become effective before my decision, I have to go under those standards. So it is not the standards at the time you submit your application, it's the standards that are in effect when the director issues the final decision. So this process occurs on a routine basis for every applicant. So I just want to make sure that we understand the process that the Department has to go through in processing these applications.

MS. TURNER-BAILEY: Thank you. Commissioner Andrzejewski?

MR. ANDRZEJEWSKI: I heard the department state that they would like to work with -- and I still call them rural counties. Have we ever written a provision in a standard with a sunset date?

MR. HART: Sure.

MR. HORVATH: Yes.

MS. TURNER-BAILEY: Any other questions or comments?

ALL: (No response)

MS. TURNER-BAILEY: I have several public comment cards. Thank you. Harry Doele?

MR. DOELE: Good morning. My name is Harry Doele, and I am the CEO of Pennock Hospital in Hastings, Michigan. Last May, when I received an e-mail from Amy as well as Representative Newell's office from the State of Michigan advising us that Pennock Hospital would qualify for a fixed MRI unit, we began to make plans build a facility at our hospital location, acquire a fixed MRI unit, hire the staff and due diligence with our board of trustees, our medical staff and our community. And we were all excited that we would have a fixed MRI unit in Hastings. Hastings, Michigan, is a community of about 7,000 individuals and the county is about 58,000 individuals. Our hospital is an 88- bed hospital that is very successful in a growing community, and we

believe that in the spirit of the regulations that you passed, that you intended for hospitals like Pennock Hospital in a county that is located greater than 30 miles from a fixed MRI unit, to have a fixed MRI unit. So between May and November, we did due diligence with our board of trustees, our medical staff and our community to prepare to have a fixed MRI unit in Hastings, Michigan. And we would like to continue to be able to do that in Hastings as our hospital can support acquiring one, purchasing one, and running that particular piece of technology. Amy did mention that many of our hospitals -- and we were one of the original hospitals that Dr. Sandler referred to, did hire some staff that have been cross-trained to do CAT scanning and MRI. We also recruited a Board Certified radiologist that's Fellowship trained in neuromuscular disease that was excited that a fixed MRI unit would be at Pennock Hospital in Hastings, Michigan. So all along, from May 27th, after I got the word from Amy and our representative at the State level that this was going to be a reality, we were planning to have a fixed MRI unit. We did rely on the website of the State of Michigan relative to the number of procedures. We did communicate with the Department on numerous occasions questions that we had. We did submit our letter of intent. We did follow procedures in a very planned and systematic approach that we felt was responsible, not only fiscally but clinically, and that would serve the citizens of Barry County. Really nothing has changed in Barry County in terms of going from rural to urban. We're urban because of commuter routes. We have folks that live in Barry County that drive to Grand Rapids and Kalamazoo and a few to Lansing to work. And that's why we were reclassified from rural to urban. This morning on my way to work -- I live 14 miles from Pennock Hospital -- I had to brake for at least a half a dozen deer, a pack of turkeys and one fox. And I have to tell you that that's driving through 15,000 acres of state land in the Barry/Yankee Springs area. So I would really hope that you would understand the situation that we present here, and that we would like to proceed. We believe that the language that has been proposed by the MHA with the Department is something that we can reasonably work with and that we can achieve within these time frames, and we are not looking for any other exception relative to any other health care projects that may concern you from a precedent-setting standard. I would also say that at the time in May when I was the chief operating officer, that was my job to look into this type of technology, to explore the costs, to go to the medical staff to discuss these issues as well as the Board and be a representative of the hospital and the community to get feedback. We had a leadership change in August. I became the interim CEO until about November 19th, when I became the permanent CEO. But all along in that process, I was the individual that was involved in this particular issue at Pennock Hospital, and today as well. I thank you for your time. I thank you for the fact that you've read the letter that we sent, and I'm available for questions.

MS. TURNER-BAILEY: Thank you. Are there any questions?

ALL: (No response)

MS. TURNER-BAILEY: Randy DeGroot?

MR. DOELE: Thank you very much.

MR. DeGROOT: Good morning. My name's Randy DeGroot and I'm the CEO of Community Health Center of Branch County. I believe all of you are aware of the situation as it relates to our application for a fixed MRI. And due to recent unforeseen changes in the Federal census count which resulted in counties that we share a mobile route with being reclassified, our volume data was negatively impacted. I think it's important to recognize that our actual volumes have not declined. In fact, they have increased. And I verified yesterday with our mobile provider that the volumes to be reported with the May update will demonstrate that increase. Also, it's important to note that CHC's county classification has not changed. We continue to be classified as a rural county. As a county-owned hospital, we methodically went through the process of submitting our CON application with full reliance on the published data that supported it. We held the committee, we sought public approvals, we had public support that needed to be garnered, we engaged architects and site visits were completed. All of this resulted in our application being submitted December 1st of 2004. On December 15th, we were informed that the procedure counts that we had relied on had recently been updated. Due to a reclassification of Barry County, we would no longer qualify for a fixed unit. I'm appealing to your sense of fair play to consider and approve the language being presented today to correct this inequity. All of the reasons that the Commission unanimously supported the previous changes in the standards, which indicated that CHC would qualify for a fixed unit, remain in place today. Thank you. And I'd be happy to answer any questions.

MS. TURNER-BAILEY: Thank you. Are there questions? Commissioner Andrzejewski?

MR. ANDRZEJEWSKI: If you were allowed to pursue this matter, how long would it take you to obtain that equipment?

MR. DeGROOT: We have -- we actually -- and I have a planning meeting at noon today which the architect will be showing the plans to our planning committee, we are immediately prepared to go out to bid to a construction manager. So that would start the process. And we believe we can have that up and running in about 9 months. We're about 9 months to 12 months out to have it up and running.

DR. SANDLER: Let me make a comment. MRI planning is different than other planning in imaging, because you have to have the shielding -- you have to construct something which shields it, not just lead line a wall. And that does add significant time and cost. That would be the explanation.

MS. TURNER-BAILEY: Thank you. Any other questions or comments?

ALL: (No response)

MS. TURNER-BAILEY: Thank you. Senator Cameron Brown?

MR. BROWN: Thank you very much. I made a mad dash from session to get here and didn't grab my suit coat, so forgive the informality. I think Randy has made his case very eloquently. I'm simply here to add support to that. I trust you've received a copy of my letter. Let me just say that I certainly supported the changes that were made last year. It generated a huge amount of good will and it was a wonderful relationship between the legislative offices and the good work that you do. And so I appreciate what we collaboratively achieved last year. Unfortunately, two hospitals have fallen through the cracks in this process including one in my district, the Community Health Center of Branch County. I'm simply here today to support the proposed changes to the MRI standards. I think it would go a long way to providing quality health care that's deserving in our rural communities, and a huge boost to the people that need this kind of medical attention in my district, and in many rural districts. So I think it's consistent with what we tried to accomplish last year and, good members, I urge your support. Thank you.

MS. TURNER-BAILEY: Thank you. Are there any questions?

ALL: (No response)

MR. BROWN: Thank you.

MS. TURNER-BAILEY: Matt Sweeney?

MR. BROWN: He's with my office.

MS. TURNER-BAILEY: Okay. Barbara Jackson?

MS. JACKSON: I'm Barbara Jackson, with Economic Alliance for Michigan. As Dr. Sandler indicated, we were a part of the group last year, and we do agree with the spirit of the agreement. We just have some concerns about the policy and the mechanics of this sort of new set of solutions. Our idea really was to address the solutions and the mechanics, come in June, and then let the final action take place in September and then that would effectively take care of the November 1st date of listing deadline. But we do understand the issues and we were a part of it and we continue to be a part of it. It's more the mechanics and the policy. Any questions?

MS. TURNER-BAILEY: Any questions?

ALL: (No response)

MS. JACKSON: Thank you.

MS. TURNER-BAILEY: Commissioner Sandler?

DR. SANDLER: Are you open for discussion now?

MS. TURNER-BAILEY: Uh-huh (affirmative).

DR. SANDLER: Here's what we learned when we met with all these hospitals. First, fixed MRI's and mobile MRI's theoretically would give you the same image. They may not if the mobile MRI is out of kilter because of the Michigan roads, but in theory they give you the same image. The reason to go to fixed MRI was the difficulty in moving patients when the MRI is not good. If you have an MRI three or four days a week and there's an emergency the next day, you have to take the patient by ambulance to Kalamazoo, to Jackson, to Grand Rapids, and it's extremely difficult to do. There was an incident recently for Hillsdale, actually the patient was gone 17 hours before they returned. The quality of patient care does suffer under those circumstances. We felt we were dealing with only a small amount of units, and I think everyone, particularly the business people, should recognize that we were very careful not to change the volume requirements of MRI. University of Michigan, Henry Ford, Beaumont, they're not going to be in any better position to get an MRI, whether this is approved or not. It was only to fix the fact that in rural Michigan, particularly in the winter, it is very, very difficult to move mobile MRI's and patients who cannot wait until the mobile MRI comes back. The recommendation I would have to the group is that we do send this for public comment, and I think the Department should be able to fix this before we meet in June. And if they think we need a better fix, then we should recommend to this Commission not to take final action. I mean, you can't do that. But I think we need probably to get off the dime. My concern is if we don't start the ball rolling today, these same institutions are going to have to delay all their planning for an additional three months, and the patients won't get this and we're going to be in the winter months and they won't be able to construct anything. We -- as Senator Brown said, we were significantly more popular in rural Michigan after this occurred and I think we -- this is in the spirit and I would make a motion that we send this to public comment with this language, with the caveat we are depending on the Department so we all aren't sued and end up in jail. Hopefully you can do that.

MS. TURNER-BAILEY: I'm in favor of the not going to jail part. Commissioner Goldman?

MR. GOLDMAN: I would support part but not all of that motion. The part of the motion I would support is sending it to public hearing. The part about going to jail is not the part I would support. But what I'm concerned about is that we not do something that I agree is for the benefit of the people of the State of Michigan and for the benefit people who have a difficult time getting the access. But I don't want to do something that would violate other rules. I mean, these counties got reclassified because they got more population; whether the population chooses to seek their services at those hospitals or elsewhere, they got more population, they got reclassified, that's what happens. If you've been driving on the street for 25 years, it's 35 miles per hour and it got changed to 25 miles per hour, you're supposed to go 25 miles an hour. And I don't want to do anything to fix this problem that would cause us other problems down the road. So I certainly agree that we should move it to public hearing and work with the Department so we can see if there is a solution that doesn't get us into a bigger problem with the whole approach to applying for and obtaining services under the current standards. I don't want to do anything that would interfere with that. And, again, I'm not -- it's not a question of the commissioners going to jail, it's a question of upsetting the whole delicate balance of the Certificate of Need standards.

MS. TURNER-BAILEY: Was that support for the motion?

MR. GOLDMAN: That is support for the motion that we send it to public hearing; yes.

MS. TURNER-BAILEY: Amy had a comment.

MS. BARKHOLZ: Just two things. I support that motion, and I would only add that the counties that were reclassified actually did not gain population. They were only reclassified because of the commuter route criteria being added. In fact, they lost population.

MR. GOLDMAN: Right. But they were reclassified because of a Federal standard --

MS. BARKHOLZ: Right.

MR. GOLDMAN: -- that we use throughout the fabric of the Certificate of Need regulations.

MS. TURNER-BAILEY: Commissioner Hagenow?

MS. HAGENOW: I think this is a classic case of where when it's a complex organism, you get unintended consequences. And as a result, I think that the people should not be impacted negatively and we should act expeditiously; but we also should have the correct advice so that we don't do another unintended consequence, which I think would be further making it negative if we go forward. So I think the public hearing -- but there must be something that also says that that's going to be guarded, that's going to reviewed, it's going to be studied intensely so that when we get to June, that we can make an action after the public hearing and not hurt these people way into the fall.

MS. TURNER-BAILEY: Did you --

DR. SANDLER: The only thing I would say is that I've agreed with both the comments by Commissioner Goldman and Commissioner Hagenow. We are making the assumption the Department will clean up the language and be legally comfortable with the language that will come back to us in June.

MS. TURNER-BAILEY: And that was, in fact, a part of the motion.

DR. SANDLER: Otherwise we're not going to approve it.

MR. HART: The -- one of the concerns we have is the one that has to do with the language that's in front of you gets sent to public hearing. We need to have a portal through which we can work with that so the hearing would get set somewhat later on and we would have a chance to work with this language and see if it's substantially changed, at which time chatter with Counselor Styka says then you might need another public hearing. So if it gets substantially changed, that's -- you're running down that road. So that would be our task, to see if we could work out something that doesn't upset the apple cart to the point of where it needs to go to a public hearing because it's substantially changed.

MS. TURNER-BAILEY: Commissioner Hagenow?

MS. HAGENOW: What about the notion of it's provisional and it sunsets in so many months? I mean, does that inhibit a delicate balance change, but you clearly made the statement but it's sunsetted? I thought that was a great idea, but I don't know enough about --

MR. HORVATH: In a sense what they are proposing is the language already has a sunset. Now, what the intended sunset is and how the Department interprets the sunset are two different things. They believe that this language only impacts one publication. We believe this could impact all the way till 2007. Because of the way the current administrative rules are structured and the current MRI standards are structured, it is an application submitted and the list that is in effect at the time this application is submitted. This says -- the language currently says that this will go to December of 2005. That means that it will be the November of 2006 list that will capture the December of 2005 data. Now, I know I'm getting too technical for you, but I've learned it from Stan. But if it goes all the way to the November list of 2006, that means applicants under the administrative rules have all the way till May of 2007 on the next published list. So our concern is although it only impacts four counties, that's one concern. The other concern is that even though these presenters say that this has -- they have no intent to seek in this change or modification to other standards, they do not speak for all applicants in those four counties. So while one can assure you that you might not seek the same remedy in the surgical standards, which also include the PA 619 language of "rural," some other applicant could hold this up as an example and be concerned and say, "You've made this provision for the rural status or the added exceptions to these four counties, should it not also" -- because it's similar language in the surgical standards, we have asked Ron to take a preliminary look at that. But because it was such short notice, I don't know if he's had an opportunity to.

MR. STYKA: I did not have a lot of time to look at this, and would like more time to look at it, just remember that. I don't think there's anything in the law that compels you to act on this. I mean, we were hearing some hints that -- detrimental reliance, whatever -- that you need to act on this. So I don't think -- those hopefully go away. And right now, I don't really see a legal problem with the language that's proposed. But if I give it more careful study, you know, you don't know. But looking at it quickly -- I mean, that's the truth of the law. You don't get a chance to look at everything when you look at it quickly. But just looking at it the way it is, I don't see a problem. You know, standards can differ from each other, as long as you have a rational basis for those differences, and in fact they all do differ from each other. And I don't really think it's a good argument for someone else to come in and say, "Well, but you did it over there." It's got to --

MS. TURNER-BAILEY: That doesn't compel us to do anything?

MR. STYKA: There has to be a rational basis. So sending it to a public hearing is probably a good idea in terms of not -- you know, it gives you time, it gives me time, it gives everyone else time.

MS. TURNER-BAILEY: Commissioner Deremo?

MS. DEREMO: Is there a legal way, then, to apply this language strictly to the MRI standard and have something in the language that would say that this did not apply to any other standards within the Certificate of Need so that the sunset provision is specifically related to these MRI standards and not to anything else?

MR. STYKA: This is the MRI standard that you're talking about.

MS. DEREMO: I know. But I'm just saying what the Department is saying is that they're concerned that this opens the door to surgical standards and all other standards. Isn't there a way in the language --

MR. STYKA: Well, I'm not buying into that door. But this change is the MRI standard.

MS. DEREMO: I understand. I'm just saying is there something that we could put in this language that would say that it --

MR. STYKA: No.

MS. DEREMO: -- could not apply to --

MR. STYKA: No.

MS. DEREMO: -- the precedence could not apply to any other set of standards?

MR. STYKA: No. Each set of standards stands on their own.

MS. TURNER-BAILEY: Commissioner Hagenow?

MS. HAGENOW: So then we're saying we have the right to make an exception and it doesn't have to be extrapolated to others?

MR. STYKA: Well, the language here, you know, in our first look is -- the issue that I hear a lot is -- or that I'm hearing is, does this contravene what the statute says as far as definition of "rural" where actually this uses the definition of rural. It doesn't really contravene that definition, it uses it to come up with a classification which you have to decide, as a matter of policy, whether it's rational or reasonable to make that difference.

MS. TURNER-BAILEY: I think I'm going to call on myself. My concern actually goes back to Larry's comment earlier, which is the rules are that the entities seeking a CON, that it applies to whatever it is at the time the decision is made. So there are always possibilities that things might change along the way. And I guess that is probably a bigger concern to me than the other piece of it.

MR. STYKA: Well, the reason the rules say that is because the courts have told us that.

MS. TURNER-BAILEY: Okay. And I think that's where a question might come up later as much as anything, that, "Oh, gee, we started this process and then things changed before we got our CON and now we can't get it." Yes, Amy?

MS. BARKHOLZ: Yes; I just want to comment exactly on that. That is why we're coming to you, to go through the actual formal and appropriate process to change the standards. Because what we didn't want was for these two applicants to try and maneuver in some way to get something that did what the rule said they couldn't. I mean, you're right. If they had gotten their applications completed earlier, they would have fallen under the better provisions. They didn't for a variety of, I think, very good reasons that you've heard. So that's the whole point. We're not trying -- the Department didn't do anything wrong, they did everything right. And they told us, you know, "Gee, we sympathize with you, but we don't bend rules." The CON Commission -- your standards changed and you can't -- "The CON standards changed and we can't change them. We can't change them back because it's not our job to do that. That's the CON Commission's job." And so that's why we came to you with this proposed language. I hear exactly what, you know, Bill and Larry are saying and I respect their points of view. I also hear what Ron's saying and completely agree. We tried to keep this narrow; keep it to the MRI standards only, put a sunset on it, and have the rationale that, you know, these two hospitals were in a different position. You have the ability to do that. I am totally fine, and I think these guys are, too, with if you decide to move it forward to public comment and the Department wants to work on slightly different that meets with their comfort level better of following that route. And like you all said, when it comes back to you in June, it's in your hands. You're taking proposed action, not final action. So in June, take final action if you choose, don't take final action if you choose, or allow a tweaking of it. That's your choice. Let's just keep this moving by taking proposed action now to put it up for public comment, which I think is the motion that's on the table.

MS. TURNER-BAILEY: Commissioner Sandler?

DR. SANDLER: Two quick comments. First, I'm delighted that the Department doesn't bend rules. Second, in March, this was preliminary action last March and I think final action last May. There would be no precedent for other hospitals to come in now for some other standard. This was all based on the time that this was classified as rural. I don't feel it would be a precedent established by this because we did the planning way before the change. It's just that the two hospitals, for whatever the reason, did not apply quickly enough. They had to, obviously, research this.

MS. TURNER-BAILEY: Mr. Christensen?

MR. CHRISTENSEN: Just from a point of perspective, when we were debating the MRI standards, there was one side of the position that said that every hospital should have an MRI. And then there was another side that said, no, it needed to be limited in some way. And so that there was a feeling at the time the MRI standards were considered that these are important pieces of technology for hospitals to have. The listing was put before the committee, which identified those who likely would qualify under this standard. And these individual hospitals were involved in that. So from a conceptual point of view, we don't have an objection to the standard as it's presented. There may be some technical tweaking in the language that would be necessary, but other than that, we support it. We could do that, too, after the public hearing.

MS. TURNER-BAILEY: Any other questions or comments or discussion?

ALL: (No response)

MS. TURNER-BAILEY: There is a motion on the table to move this language forward for public comment with the understanding and caveat that the Department will work to make any necessary changes to increase their comfort level so they can come back and give us a positive recommendation in June. It has been supported. All those in favor, please signify by raising your right hand?

ALL: (Affirmative response)

MS. TURNER-BAILEY: Opposed?

ALL: (No response)

MS. TURNER-BAILEY: It's unanimous. An interesting situation. It's :10 to 12:00, we have another presentation that -- I don't know if this is going to take a lot of discussion or not.

(DR. Sandler leaves the room)

MS. TURNER-BAILEY: I'm going to push forward because we do have a very lengthy agenda, still about 13 more items, even after this one. So at this time, I'd like to call the representatives from Karmanos Hospital; Dr. --

DR. RUCKDESCHEL: Thank you for the opportunity to be here today. I'm sorry that this appears to be something that's on relatively short notice, but we have actually been working with the Department now for the better part of a year and a half on this issue. And it only became apparent recently that there were other potential matters, which is why this seems to be coming forward to you rather quickly. Karmanos Cancer Institute is a unique organization in the State of Michigan. It is one of two institutions that has a National Cancer Institute designation, which requires a substantive research presence. It is the only institution in the state that's, effective May 1st this year, will be a freestanding institution with NCI designation. That's an important distinction. There are only 9 or 10 freestanding cancer centers in the United States. They are names that you know well, Memorial Sloan Kettering, M. D. Anderson, City of Hope, Fox Chase in Philadelphia, St. Jude's in Memphis, and Moffit Cancer Center in Tampa, which I chaired before -- I was president before I came here to Karmanos. In addition, this group of hospitals, when the original Medicare rules were put into place under the PPS -- prospective payment system -- in the early 1980's and later with the balanced budget act in the 1990's, where prepaid and preset rates of reimbursement for first inpatient and then outpatient care were put into place, so-called APG's, or ambulatory payment groups it was recognized that cancer-only facilities could not survive under that. You don't have positive reimbursed specialties like orthopedics or obstetrics or heart surgery to offset losses you might have in less predictable cancer business with a single group of patients. And so those eight or 10 hospitals were made exempt from the original PPS legislation. And subsequently three or four other hospitals joined them, including the facility in Tampa that I led. The most recent to do that was Ohio State, with the James Cancer Hospital of Ohio State, where the James did exactly what we're doing, split off from Ohio State, became a separate entity and applied for this status. More recently in the balanced budget amendment in the late 90's when ambulatory groups were put in place, the same realization was seen. And these same institutions remained exempt from that. What does that mean? It means that these institutions are paid on a cost-to-cost plus -- it's complex; we call it "cost-plus basis" -- as institutions used to be paid under Medicare. It does not affect how they are paid by other insurers. But it does affect how they are paid by Medicare, which is about a third to 40 percent of the business of most major cancer centers. The major advantage for it is not that the reimbursement is better, it's that the tax on new treatments and new technology disappears. For example, whenever we put in a new treatment or a new technology, until Medicare gets around to declare the appropriate billing codes for it and the appropriate category for it, we get the old reimbursement for it, not the new reimbursement. As an example, for the last two years, patients who had melanoma, which is a skin cancer that arises in moles, the treatment of which is a five- or six-day hospital infusion of Interluken 2 goes way over the DRG. And every time we admitted a patient to treat for this, it cost us an automatic $30,000. We knew that right off the bat when they came in. Now, we don't do anything different, we end of the year when the Medicare cost report goes in, then we get reimbursed for that difference. That's the benefit for cancer institutes. So we have completed a -- now a multi-year process of separation from the Detroit Medical Center; an agreement was reached -- a final agreement -- last August. For months before that, we've worked with the Department and other interested parties, including the -- more recently, the Economic Alliance, in order to sort through the issues that were involved in this. We are moving nowhere. We are taking the beds that we have operated under a management agreement with the Detroit Medical Center for the last decade, and will take them over on an ownership basis, effective May 1st. We are not building any -- we are not creating any new beds. We are not creating any new entities. We are not moving anywhere. All the facilities and all the things we operate in downtown Detroit will remain there. And that's important because we are the cancer center that serves the safety net population in Detroit. We see that population. Our cancer center, from a research point of view, is focused like no other cancer center on the disparities of cancer in African-Americans. Both our population programs and our clinical research programs are focused truly like no other cancer center in this country is focused on those. So we are

remaining there, we stay in place. We have completed that agreement. And as I said, the sale completes May 1st and we are now in the process of completing those documents. We are also in the process of completing the PPS exemption with our congressional delegation in Washington. They are looking to our CON status as part of the coming out to do that, and -- so part of the reason why we're here. Now, we spoke to staff at the Department when this began, close to two years ago, probably a year and a half ago, and were assured after a tour of the facility that there would be no problem in sale of a partial -- portion of the beds of the hospital; that this was not in particular an issue. It wasn't prohibited by the statutes; et cetera. Obviously, later on, concerns were raised, both within -- well, very recently within the Department and from other parties that the partial sale of assets would result in opening a precedent for other institutions to buy portions of assets and create all sorts of boutique facilities and drive a tractor-trailer through the CON statutes. We respected that. We understood that that was an issue. I've taken counsel of any number of individuals and groups who can speak for themselves as we go through this and have determined that the simplest, most focused way to do this is to create a minor change in the CON statute that really makes us look like a long-term acute care facility by adding that terminology to that bill. It actually also ties us to gain the same sort of Federal designation, or similar Federal designation that those facilities do. It would limit it to one institution. There is no other institution in the state that now, or even potentially in the future, would be eligible for this particular exemption -- for the PPS exemption. And, in fact, there are probably not two other institutions in the country that would be eligible to go down this route to be a freestanding, cancer-only facility. The wording changes that we have requested and the amendment that's with it just reaffirms that the BMT program which is part of this also stays on the same site, basically addresses a very minor change that would allow us to move forward -- which we would appreciate -- to public comment on this. We have a chicken and an egg situation with some of the CON field looking to see about our PPS exemption. And, of course, the folks in Washington wanted to see about the CON portion of it. We think they both go together. They're tied together in this particular piece of legislation. The bone marrow transplant program we have also operated for the Detroit Medical Center, now -- really since its inception. And since that's covered under a different piece, we've just proposed the same methodology for doing that. There are no Medicare losses to any other entity. This is a -- as they say at the Federal level, a not -- this cannot be recognized in the Federal budget. This changes -- the amounts of money are so small, it's unrecognizable for them. It will bring more -- ultimately more Medicare money to the State of Michigan and we think it would be a major benefit for the City of Detroit and the areas surrounding those counties. So we would ask that you adopt this resolution today to move this forward to public comment and we'd be happy to take any questions.

MS. TURNER-BAILEY: Thank you. Are there any questions? Commissioner Young?

DR. YOUNG: My one concern, what happens if you do not get this PPA exemption?

DR. RUCKDESCHEL: It's a matter of -- yes; it's a possibility we wouldn't get it. We'd have to come back then and deal with that. All of the institutions, including the one I previously led, it's a matter of satisfying certain criteria. The criteria for PPS exemption is economically free-standing and National Cancer Institute designated cancer center, which there are 50 altogether, 39 of the category that we are, which is comprehensive, and third, over 50-percent of your business has to be in a certain set of DRG categories labeled as cancer by Medicare. It's a very ruling of it. As I said, there are only a dozen institutions in the entire country that either do or conceivably could meet that requirement. We are one of those institutions.

MS. TURNER-BAILEY: Commissioner Hagenow?

MS. HAGENOW: Perhaps you addressed this. But one of the great concerns around niching anything is the fact that it prunes off and doesn't do the Medicaid population. I heard you talk about Medicare, but I didn't hear anything about Medicaid. I know by your location that you would seemingly have -- are you expecting any change or anticipating that as a free-standing, away from the hospital, that there would be any kind of change in that Medicaid coverage, where the hospital winds up with the Medicaid and you get the others; that kind of thing?

DR. RUCKDESCHEL: No. We continue to take all of Medicaid patients. In fact, as you may understand, when you're diagnosed with serious cancer, you automatically get Medicaid. So Medicaid is just one of our payers at 17 percent of our business. It's there; we've always taken care of it. We've never asked for any of the special funds for the safety net population; it's just part of our book of business.

MS. TURNER-BAILEY: Commissioner Sandler?

DR. SANDLER: This is slightly off the top -- like a regular hospital, you will need ancillary services, obviously; radiology, pathology, anesthesiology in some cases, et cetera. How do you plan to go about and what time frame, to gaining these services?

DR. RUCKDESCHEL: Many of the services we will obtain under a purchase services agreement with the Detroit Medical Center. Others will come under arrangements with the Wayne State University School of Medicine and its various faculty groups, practice groups to provide those services to us. To the extent that we, as a facility, require ancillaries or any other element of our operations, we'll either be purchasing them from the Detroit Medical Center or seeking to come through the CON standards. There are no -- we don't seek any exceptions for MRI or CT or OR's or anything else. We will come through the normal procedures for those.

DR. SANDLER: Do you plan to have your own MRI and PET scanning and things like that?

DR. RUCKDESCHEL: Yes, we do.

DR. SANDLER: Separate from Harper?

DR. RUCKDESCHEL: Yes. But realize that as part of the sale, Harper, if they're looking to sell us 120 to 125 beds, whatever, is they will decrease their complement of beds by a like amount. In the process, when they sell us operating rooms, they decrease by a certain amount. Whatever they sell us, whatever we take, they decrease. In those areas where we have the numbers of cancer patients to support for example, PET CT, we would put that into place. Now, we are obviously doing planning with the Detroit Medical Center in that we will remain partners, if you will, on the same campus. It's hard to avoid each other since we're tied at the hip quite tightly. But they obviously will not invest in a PET CT on the Harper side of things because 95 percent -- or, 90 percent of the business is going to be in the cancer field. So we understand those issues as we go forward. And that's how we'll obtain them.

DR. SANDLER: Thank you.

MS. TURNER-BAILEY: Commissioner Goldman, did you have a question?

MR. GOLDMAN: Yeah; I just -- I had two questions, one of which you've just answered, and it's the reason for why you have the language about, except CON approval set by cancer hospital for clinical services, then you list bone marrow therapy, CT, MRI, PET, surgical services. So your plan would be to obtain those services for your facility through a Certificate of Need approval rather than through a contract with Detroit Medical Center?

DR. RUCKDESCHEL: Well, it will vary -- right. Some -- for example, a medical intensive care unit we will likely obtain under contract with the Detroit Medical Center. All the other non-cancer services we would obtain under contract or purchase service through Detroit Medical Center. Where something is completely integral to the care of the cancer patient or the diagnosis of cancer, we will move to establish that in our facilities and to seek the appropriate CON approvals in every instance. We're not asking for any exceptions there.

MR. GOLDMAN: And the second question is just for my own understanding. You indicated that you believe you are the only program in the state that would be able to obtain this designation. And I'm just curious about why the University of Michigan couldn't do the same thing that Ohio State University did and essentially the same thing that you're trying to do by making an economic freestanding facility?

DR. RUCKDESCHEL: Michigan could, in fact, do that if it chose to. I think it -- like Hopkins and Stanford and Duke and many of the other major universities in this country, their decision a long time ago was to leave their cancer center integrated with the rest of their medical facilities.

MR. GOLDMAN: No; I understand that. But there's nothing in this proposed language that would prohibit that from happening?

DR. RUCKDESCHEL: That's correct.

MR. GOLDMAN: And if it did happen, it wouldn't have any adverse affect on the Certificate of Need standards in the same way that you're approach would not?

DR. RUCKDESCHEL: Exactly.

MR. GOLDMAN: Thank you.

MS. TURNER-BAILEY: Are there any other questions?

ALL: (No response)

MS. TURNER-BAILEY: Any further discussion?

ALL: (No response)

MS. TURNER-BAILEY: Is there a motion?

MR. GOLDMAN: I move approval of the --

MS. TURNER-BAILEY: I'm sorry -- I had another -- I apologize. I should call Eric Fischer. Can you hold that thought?

MR. GOLDMAN: I probably could; yes.

MS. TURNER-BAILEY: Sorry about that.

MR. FISCHER: Hello; I'm Eric Fischer from the Detroit Medical Center. Seeing that it's close to lunch, I'll be extremely brief. We at the Detroit Medical Center would like to vocally support Karmanos' proposal for this resolution. Thank you.

MS. TURNER-BAILEY: Thank you. Commissioner Goldman?

MR. GOLDMAN: I would move that we take the proposed changes forward to a public hearing.

MS. DEREMO: Support.

DR. RUCKDESCHEL: That's with the amendment -- that piece about the bone marrow transplant?

MR. GOLDMAN: The proposed amendments; both the -- that amendment and the bone marrow amendment.

MS. TURNER-BAILEY: Okay. So both?

MS. DEREMO: Support.

MS. TURNER-BAILEY: Okay. It's been moved and supported that we move the proposed language changes and amendments proposed by Karmanos for public hearing. Is there any discussion? Brenda did you have a comment?

MS. ROGERS: No; I just wanted to be sure that you were including both sets of language.

MR. GOLDMAN: Yes.

MS. TURNER-BAILEY: All right. Any further discussion?

ALL: (No response)

MS. TURNER-BAILEY: All those in favor, please signify by raising your right hand.

ALL: (Affirmative response)

MS. TURNER-BAILEY: And apposed?

ALL: (No response)

MS. TURNER-BAILEY: Seeing none, it's unanimous. Okay. We're going to break for lunch. We will reconvene at 1.(

Off the record)

MS. TURNER-BAILEY: It's 1:05. I apologize for getting us started a little bit later than scheduled. We are going to move on in the agenda. Next on the agenda we have the CON Commission Bylaws, which should be in your binders. I am going to probably ask, depending on the time that we use here, we may -- I may ask the commissioners for permission to move the election of officers up a little sooner in the agenda because we do have some people that may need to leave before the conclusion of the meeting. And I want everybody to have an opportunity to participate. So we'll see how things are going, timewise. But I just want to throw that out there. Hopefully, everybody's okay with that. Item XI, CON Commission Bylaws. Mr. Styka?

MR. STYKA: Interesting how with the law, there's always something else to look at. As I was just glancing at Article I in the preamble, I realize that we failed to change "Public Health" to "Community Health." While we're at it we should do that. I just read right past that. "The Michigan Certificate of Need Commission is created in the Michigan Department of Community Health" instead of Public Health.

MS. TURNER-BAILEY: Are we looking at the -- I have a yellow version.

MR. STYKA: Yeah. What I'm using is the same as the yellow one.

MS. TURNER-BAILEY: Okay.

MR. STYKA: Mine's on one side of the paper so it's easier to read.

MS. TURNER-BAILEY: I just want to make sure we're all looking at the same version.

MR. STYKA: All right. So, we're talking about eliminating Article IV, because it's redundant with statutory provisions. This is the same as when we were here last time. And then we have a new Article IV which replaces the old Article that dealt with ad hoc committees, and this is the Standard Advisory Committees. And we went through these last time. Do you want me to --

MS. TURNER-BAILEY: Yeah; if you would.

MR. STYKA: Okay. It says you can have them. "The duties of the Standard Advisory Committee shall be developed by the Commission at a regular or special meeting. A Standard Advisory Committee's duties shall be adopted by a majority of the Commission. The duties of a Standard Advisory Committee shall be set forth in a written charge, enumerating the duties delegated to it by the Commission. The language of the written charge" -- and this is a little different than what you saw the last time -- "The language of the written charge maybe adopted by vote of the Commission or the Commission may delegate the chairperson to write the delegation" -- should say --

MS. TURNER-BAILEY: "The charge."

MR. STYKA: -- "charge."

MS. TURNER-BAILEY: And the commission, the first "commission" there, should be capitalized; right? "Commission" should be capitalized all the time; correct?

MR. STYKA: Yeah.

MS. TURNER-BAILEY: So we need to make that change as well.

MR. STYKA: -- "write the charge consistent with the action of the Commission."

MR. STYKA: So what we've done -- stopping for a moment -- is we say that it's the Commission that will develop the actual duties and the charge for the advisory committee. But if the Commission doesn't actually go through the process of adopting a certain paragraph, but instead we know by the motion and the discussion what it's all about, it can instead delegate that actual writing of the paragraph to the chairperson of your choice. And it may depend on what -- how much time you have, if it's a complicated one and nobody's pre-written it, you may just want to delegate it to the chairperson. You have that option. "D, the members of a Standard Advisory Committee shall be appointed by the chairperson consistent with statutory requirements and the recommendations of the Commission." And that's consistent with what you've done in the past with ad hoc committees. The rest of the language is from the old ad hoc committees. "Appoint of a Standard Advisory Committee shall be effective as of the date of the first meeting." Oh, that one is new last time.

MS. TURNER-BAILEY: That's new.

MR. STYKA: That was new last time. I guess the version I'm looking at doesn't necessarily show that it was -- it's showing what's new since last time, but not from the beginning in all cases, like it should have showed. In any event, "The appointment of a Standard Advisory Committee shall be effective as of the date of the first meeting of the committee." That was to deal with our time crunch issues, so the six months doesn't begin to run until we actually start meeting. "The chairperson of a Standard Advisory Committee shall be appointed by the chairperson of the Commission." That's the way it has been. "A member of a Standard Advisory Committee shall be subject to provisions against conflicts of interest" -- that's as it has been -- and "all meetings shall be Open Meeting compliant," which is as it has been. We then take out the "Oversight by the Michigan Legislature and the Governor." Since that is covered by the statute, it doesn't need to be in your bylaws. We take out the "Ad Hoc Advisory Committee," the old article, because we now don't have those; we have Standard Advisory Committees. Then we go to Article V, which is the membership of the Commission. This is pretty much in the statute, too. But it seemed logical to have it here, just because if somebody's looking only at the bylaws it would be a logical place for them to look. So we have the 11 members and then we have the breakdown of who they represent. But that's actually duplicative of the statute.

MR. GOLDMAN: Just a technical -- on V, A, we talk about "Section 22211 of the code."

MR. STYKA: It should say "Public Health."

MR. GOLDMAN: Yeah; because otherwise --

MR. STYKA: It may be at the beginning that we -- did we -- I think we made it so -- yeah. If you look at Article --

MR. GOLDMAN: In the preamble, it says.

MR. STYKA: -- 1 in the preamble, it has that Part 222 of the Public Health Code is --

MR. GOLDMAN: I was just wondering; if the public's reading this, they're not going to know where to find 22211 without the 333 in front of it.

MR. STYKA: Well, it's used a lot throughout here. Do you feel strongly that that should be --

MR. GOLDMAN: No; I just want to make sure the people understand it.

MR. STYKA: Okay.

MS. TURNER-BAILEY: So we're not going to make a change there because we need --

MR. GOLDMAN: I think that's okay.

MR. STYKA: "Term of Office," again, this is actually something that's actually in the statute. We changed it to comport with that, "Newly appointed commissioners take office upon appointment of the Governor. Unless rejected by the Senate, commissioners then serve until their term of office expires and their successor takes office or their resignation is accepted by the Governor." "Members of the Commission, with the exception of initial members, shall serve for a term of three years or until a successor is appointed." Those are to be consistent with the law and we had a couple years ago some advice I gave you which is also reflected in here, in terms of terms of office and when you take office and when you don't. "Quorum, A majority of the CON Commission members appointed and serving shall constitute of a quorum." So you could have six -- if you have 11 appointed, six people would constitute a quorum. That doesn't answer how many votes it takes. That's in the next sentence. "Final action by the Commission shall be only by affirmative vote of a majority of the CON Commission members appointed and serving." That's because that's what the statute says. So if only six showed up, you'd have a quorum, but you'd need six votes to get something done. "Actions not resulting in final action" -- and this is a new provision -- "including recommending action by the full Commission or completing other planning tasks may be made by a majority of those in attendance." The statute very carefully uses the words "final action" when it talks about needing a majority of all those appointed and serving. So there's got to be some reason for that. And it seems to me some of your housekeeping duties that sometimes you do during the end of the meeting when you've lost some of those people, you can do by a simple majority, such as setting up your work calendar, et cetera. So that's what that's intended for. "The Commission members shall not vote by proxy. A proxy of a CON Commission member shall not be seated, nor shall they vote, offer motions or second motions." That's consistent with what you've had in the past. We've eliminated the financial reimbursement section. The administrative and professional staff support, that's all provided for in the Public Health Code as well. Article VI is the meetings of the Commission. First we require compliance with the open meetings act which is something that goes without saying, but we're saying anyway to make sure it's clear. We're going to use Robert's Rules of Order. "The Commission's procedural activities shall by governed by Robert's Rules of Order, Revised, insofar as they are consistent with state law and these bylaws." Because there are times when Robert's Rules are not quite consistent with State law and how State Boards and committees and commissions act. So we just want to make it clear there that sometimes they could get overruled by the law. "Notice of Meetings." We're changing this one to say that "the Department shall make available the times and places of the meeting of the CON Commission." It was a little bit more detailed before, talking about minutes and things. And I don't think we need that. The "Regular and Special Meetings, the Commission shall hold regular meetings quarterly at places and on dates fixed by the Commission." "Special meetings shall be called by the chairperson of the Commission by not less than three Commission members" -- it used to say "two," but now that we have so many more members, it seemed logical to change that to three -- "or by the Department." So you can have special meeting called by the chairperson, three of you, or the Department. "A regular or special meeting of the Commission may be recessed and reconvened consistent with" the Open Meetings Act. Sometimes -- and this was true in the early days of the Commission, you might have a meeting that goes over two days or a longer period of time. And that's meant to explain that that's how that works, where you can recess and then reconvene and it's still the same meeting. "Meeting Attendance, members of the Commission are expected to attend all regular and special meetings except on those occasions where good cause exists." We don't need to say "which includes emergencies." A good cause is a good cause, whatever it is. The statute itself makes statements like this, so it was logical to have that here. "When a member of the CON Commission is aware that he or she will be unable to attend a regular or special meeting, every effort should be made to give advance notice to the Department, which shall notify the chairperson or vice-chairperson of the Commission." It used to say "secretary," but it makes a lot more sense the way the Commission actually functions to have that notice go to the Department, who will then inform the chairperson or vice- chairperson, depending on who's holding the meeting. "The Governor may remove a CON Commission member from office for failure" -- oh, I skipped one. "The chairperson of the CON Commission shall determine whether a good cause exists for the absence of a member from a regular or special meeting"; "When the attendance of the chairperson is under question, the responsibility for determining good cause falls to the vice-chairperson of the Commission." This is because the law provides that if you miss a certain number of meetings, you could be removed from the Commission.

"The Governor may remove" -- and here it is -- "a CON Commission member from office for failure to attend three consecutive meetings in a one-year period." I think the legislature's theory there was you just don't care enough to be on the Commission. "Teleconferencing." "Teleconferencing shall be allowed in accordance with the Open Meetings Act. Upon approval of the chairperson, CON Commission members may appear at a meeting via electronic device, including speaker phone or interactive television, provided that a quorum is present at the meeting site and all individuals attending the meeting can hear and can be heard by the Commissioners attending via electronic device." In other words, you have to have at least a quorum here, six members, and those who are participating electronically, under the Open Meetings Act, it really doesn't work unless everybody that's in attendance out there can both hear and be heard by those who are electronically present. And this doesn't mean you have to do this. This is an option that's there for you in your bylaws.

MS. TURNER-BAILEY: But it answers a question that comes up quite often, so --

MR. STYKA: Well, we had it happen. We had a commissioner who was ill and it's good to have it in there. "Agenda and Background Materials, in consultation with the Department and other Commission members, the chairperson shall determine a tentative agenda for each meeting." This is a new section that Renee and I worked out, which we thought was important in light of the procedures and how they've gone in the past. Secondly, "No later than 7 days before each meeting, the tentative agenda shall be placed on the appropriate section of the Department's website. No later than five days prior to each meeting, the text of any proposed or final actions and relevant background materials shall be delivered to each commissioner, using overnight or e-mail, and shall be posted on the appropriate section of the Department's website." "Urgent action items, proposed or final" -- either one -- "meeting the statutory requirements may be added to the agenda on the unanimous approval by the Commission at the start of a meeting." So this is something you may want to think about for a moment, because you have not seen this provision before. What this is talking about is making sure that you're not getting last minute items unless you agree to get last minute items. And the idea of overruling this provision through unanimous consent is something -- for example, I'm on a school board. That's how we do it. I think it's a logical way of approaching it. If something hasn't been noticed in advance and one of the members of this body really feels they need more time before you get to this, they should be able to keep it from being on the agenda that day. So that's -- if you disagree with that, now's the time to tell me. (Off the record interruption)

MR. STYKA: Any comments? Concerns?

ALL: (No response)

MR. STYKA: Article VII, "Officers and Procedures for Electing" -- by the way, today you'll be using your old provisions, keep that in mind. "At its first meeting and annually thereafter, the CON Commission shall elect a chairperson and vice-chairperson for a one-year term" -- and we've taken out "or until the next regularly scheduled meeting following the anniversary of their election." It's a one-year term and, you know, and obviously they're serving until you get around to changing them. And you're going to try to do that within that time frame of that meeting that's going to fall in that three month cycle -- "not to exceed three consecutive terms" That's what you had before. "The chairperson and the vice-chairperson shall be of separate major parties." That's what you had before. All right. "Procedures for Selecting Officers," there's really no changes here. Nominations made by any Commission member who's serving and in attendance, "Election" -- "shall be determined by an affirmative vote of a majority of CON Commission members appointed and serving." And by the way, your current bylaws say "appointed and serving." There was some question I had by one or two commissioners as to how many votes it would take to elect an officer. And I think it's consistent with the fact that the statute says you take final actions through a majority of those appointed and serving to have your election by a majority of votes of those appointed and serving, and that is what your current bylaws say. "Responsibilities of Officers, the chairperson" -- "or the vice-chairperson shall preside," et cetera. There's no change there. "The duties designated to the chairperson in the Public Health Code and these bylaws, in the absence of the chairperson shall be performed by the vice-chairperson or the temporary presiding officer." And if you have need of a chairperson or the vice-chairperson present, that would mean that the rest of you could elect a presiding officer to fill in. "Filling Vacancies in Officers, if the office of chairperson becomes vacant" -- "the vice-chairperson shall vacate their position and become chairperson" -- "serving the remaining months of the chairperson's one-year term." This eliminates having to do something in the interim in terms of an election. "If the office of vice-chairperson becomes vacant" -- for any reason -- "the Commission shall elect

a new vice-chairperson by an affirmative vote of a majority of those members appointed and serving and that person shall serve the remaining months of the vice- chairperson's term." So you wouldn't have to elect a new chair, you would have done that de facto back when you selected someone to be the vice-chair. But now you do have a vacancy, the vice-chair, that you need to fill. "If the offices of chairperson and vice-chairperson" -- both -- "become vacant, the Commission shall conduct a special election to fill these positions. New officers shall be elected by an affirmative vote of a majority of those members appointed and serving and they shall serve the remaining" -- "terms" And by that -- adding the phase, "they shall serve out the remaining term," we eliminate the need for number 4. Article VIII, "Parliamentary Procedure and Legal Counsel," this is pretty much the same as it was before. The Attorney General or his representative serves as parliamentarian. "Any question arising concerning procedure at a meeting" -- "shall be resolved by the presiding officer in accordance with these laws" -- is should say "the laws" rather than "these laws" -- "these bylaws, and Robert's Rules or Order Revised." "The Attorney General of the State" -- "or his or her duly designated Assistant" -- "shall serve as legal counsel of the Commission." Article IX, "Standards of Conduct by CON Commission Members and Conflict of Interest." Of course, this was an area we also had major changes, because of the ruling by the State Ethics Board -- it's almost -- over a year now. "CON Commission members are subject to" -- and, of course, this is consistent with what the statute says, the law governing contracts of public servants, the code of ethics for public employees and officers and the law covering lobbyists and lobbying regulations. "Definition - Conflict of Interest." And this is where I used the language that's in the Ethics opinion to come up with a slightly different standard which you had before. "Under the State Ethics Act," -- "in accordance with the advisory opinion" -- "of November 5, 2004, a conflict of interest for CON Commission members shall exist when the individual member has a financial or personal interest in a matter under consideration by the CON Commission. The personal interest of a CON Commission member includes the interest of the member's employer, even thought the member may not receive monetary or pecuniary remuneration as a result of an adopted CON review standard." Now, that sounds like trouble. So we get to number 2, "CON Commission members shall not be in violation of the State Ethics Act" -- "if the member abstains from deliberating and voting upon review standards in which the member's personal interest is involved." And, again, this was the exceptions that were carved out by the Ethics Board. And then Number 3, "Commission members may deliberate and vote on standards of general applicability; that is, those standards that do not exclusively benefit certain health care facilities or providers who employ the Commission member, even if the standard of general applicability would benefit the member's employer or those for whom the member's employer does work." So if it's generally applicable, even though it may benefit your employer -- hospital, nursing home, whatever; wherever you're from -- it's okay for you to participate. It's only when it's not of general applicability that the Ethics Board found that there was a problem. In other words, it's a standard that really is designed to help one or two hospitals or nursing homes, other types of facilities.

MS. TURNER-BAILEY: Commissioner Deremo?

MS. DEREMO: Mr. Styka, many of us are on boards -- hospital boards or health care organization boards. They're not our employers. They -- we don't get personal remuneration or benefit. How do those standards apply to those situations?

MR. STYKA: The same. The Ethics Board was careful to point out that -- if you look at the last sentence of number 1, "Personal interest of the Commission member includes the interest of the member's employer" -- and I know you're saying that you're not an employee -- "even though the member may not receive monetary or pecuniary remuneration as a result of the standard." I think you can extrapolate from that, that -- and, again, it's difficult because they didn't directly answer the question. But if you look at what they said, I think they way they viewed it is if you have a board or a commission or some group that you are making decisions for, that's potentially a conflict of interest, so these rules generally would apply. And as long as it's a CON standard of general applicability, you're okay. But something designed just to help your particular group that you are serving as a decision-maker is what --

MS. DEREMO: So If I serve on XYZ Hospital Board, and a standard comes before -- or, whatever, the issue that comes before is specifically designed to assist XYZ Hospital, then I would have to recuse myself?

MR. STYKA: And maybe nobody else but maybe ABC or something and that's it, yes; then you would have to abstain. You'd be okay, you could abstain; I mean, you could stay here, not recuse yourself in the sense of running off to the back room. But you wouldn't be able to vote on it.

MS. DEREMO: Thank you.

DR. AJLUNI: Excuse me -- abstain from voting? Abstain from discussion? Or both?

MR. STYKA: Discussion, also. You could be here, but you wouldn't participate in the sense of putting in your two cents.

DR. AJLUNI: Okay.

MR. STYKA: "Procedures for Conflict of Interest. A Commission member shall disclose" -- and, again, going back to that first, I'd like it to be written better. But we've got to stick with what the Ethics Board said and this is about all they gave us. And it's not really easy for us to go beyond that at this point in time. "Procedures" -- "A CON Commission member shall disclose that he or she has a potential conflict of it after the start of a meeting, at the commencement of consideration of a substantive matter before the CON Commission, or, where consideration has already commenced at the point where" it becomes apparent that they have this. The chairperson, as part of your agenda, always asks at the beginning. So if you know ahead of time, that's the time to disclose. Maybe it isn't clear to you until the item comes up on the agenda; that's another opportunity you should disclose. Maybe it's not until you're into the discussion that it becomes clear this is a conflict or potential conflict, that's when you disclose. So it's really three possibilities. Obviously the earlier you know, the sooner you should get out of the discussion. "2. After a meting is called to order and the agenda reviewed, the chairperson shall inquire whether any Commission member has a conflict or potential conflict." We just mentioned that; that's how we've done it. "Prior to a vote on a substantive matter before the Commission, the presiding officer shall inquire" as to any conflicts. And I'm not sure you've been doing that.

MS. TURNER-BAILEY: No.

MR. STYKA: But if you adopt these bylaws, you should.

MS. TURNER-BAILEY: Okay.

MR. STYKA: I believe the old bylaws call for it already. "A conflict of interest shall not affect the existence of a quorum." So that is one plus. I mean, if you only had six members here and somebody had a conflict on a particular item, you could still function and pass it with five votes. Well, actually, no; you couldn't pass it with five votes. But you could continue to meet. Maybe a better example would be -- well, never mind. "Minutes of the meeting shall reflect a conflict of interest existed and an abstention from voting occurred." Let's see. We took out some old language that basically talked about these same things. And we substituted, "Where a Commission member has not discerned that he or she may have a conflict of interest and must voluntarily abstain from discussion and vote, any other Commission member may raise a concern as to whether another member has a conflict of interest on a substantive matter. If a second member joins in the concern, there shall be discussion and a vote on whether the member has a conflict of interest prior to continuing discussion or taking any action on the substantive matter under consideration. The question of conflict" -- "shall be settled by an affirmative vote of the majority of those members appointed and serving, excluding the member or members in question." This is basically trying to create a procedure by which you have a situation where it may not be clear to an individual that they have a conflict, but at least two of you think there is one. And then you're going to make a decision as a body as to whether or not there is a conflict. Chances of this coming up are very rare, but it's better than having no procedure. If you have no procedure, then you're stuck going back to the Ethics Board every time.

MR. GOLDMAN: Let me just make a suggestion. Under what you've just read, if you take the current number 5, about the minutes of the meetings and move it after 6, then we can get all the considerations. Because as it is now, it says, "The minutes shall reflect when a conflict of interest existed and that an abstention from voting has occurred," if you put it after 6, and you say "The minutes of a meeting shall reflect when a conflict has been determined" -- which means you can declare it or the Commission can find it -- "and an abstention from discussion and voting" -- not just "voting" -- "has occurred," then you capture the whole thought of the paragraph.

MR. STYKA: Yup. So we'll make 6 into 5 and 5 into 6, --

MR. GOLDMAN: Yeah.

MR. STYKA: -- and we'll modify the new 6 to say "the minutes of the meeting shall reflect when a conflict of interest has been determined and that abstention from discussion and voting has occurred."

MR. GOLDMAN: Right.

MR. STYKA: Anybody have any --

ALL: (No response)

MR. STYKA: So it looks like it's got consensus.

MS. ROGERS: Do you want to use "deliberation" instead of "discussion" since you used "deliberation" under number 2?

MR. STYKA: Yes; let's be consistent.

MR. GOLDMAN: Then we've got to change it in the new 5 as well.

MR. STYKA: Good catch. In the new 5, wherever it says "discussion" we can substitute "deliberation." Anything else on that part?

MS. TURNER-BAILEY: I have a couple things from earlier, which I thought we were going to go through the whole thing. I'm sorry. Go ahead and finish, and I'll --

MR. STYKA: Well, I was emphasizing this part because it's --

MS. TURNER-BAILEY: Sure; yeah.

MR. STYKA: Article X, "Amendments of the bylaws, any amendments" -- "shall be proposed by the Commission or presented in writing to the Commission by the Department at least 30 days in advance of the meeting where final action is scheduled to be taken." And then it says, "Bylaws shall be deemed to be approved upon an affirmative vote of a majority of CON Commission members appointed and serving. Amendments to the bylaws shall be come effective upon approval or on such later date as is specified within the amendments." And that was the end of the document.

MS. TURNER-BAILEY: I just have a couple of questions. The first one is -- it's earlier where we deleted the part where it said we have to have minutes. Let's see -- where was that?

MS. ROGERS: It's on the bottom of page 8.

MS. TURNER-BAILEY: Okay. I thought it was much sooner than that. It says that the times and places shall be made available, and it also says that the Department shall also keep minutes of such meeting and a record of such action of the Commission. And when we put the new language, all it says was that the Department has to make available the times of the -- and places of the meetings. And I guess I would want to keep that second sentence in there.

MR. STYKA: No problem.

MS. TURNER-BAILEY: My second comment is on that same page, the top of page 9, where we deleted the language, "announced in September preceding each calendar year," I know we went back and forth on that. But I think I wanted to vote to keep that language in there.

MR. STYKA: I've got to catch up with you. Which section are we on?

MS. ROGERS: It's immediately following that (indicating) --

MR. STYKA: And what was your comment? I missed it.

MS. ROGERS: Leave this (indicating) in.

MS. HAGENOW: That it's announced for the whole year.

MS. TURNER-BAILEY: And there were a couple of little typos that I guess when we go through it for -- whatever -- the final time, we'll make sure that those get -- okay. Any other questions, comments?

MS. HAGENOW: What did you mean by the final time? Is it three readings?

MS. TURNER-BAILEY: No; I mean when they do the "accept all changes," as an example, on page 11 under Article VII, D, when we added the new language it had a period there, so it created two periods. That's the -- you know, it's just a small thing, but --

MR. STYKA: Yeah; that should be fixed. One of the problems is when you do this strike thing in addition to format, sometimes it's difficult to --

MS. TURNER-BAILEY: I appreciate seeing the changes. So at this point, I can take a motion to accept the bylaws as amended and if we pass that, these are the new bylaws; right?

MR. STYKA: I believe so.

MS. TURNER-BAILEY: Okay. In that case, I'll accept a motion at this time. Oh, I'm sorry -- Commissioner Ajluni?

DR. AJLUNI: I move we accept the bylaws as presented by Counselor Styka.

DR. SANDLER: Second.

MR. STYKA: "And amended here."

MS. TURNER-BAILEY: And amended here. It's been moved by Commissioner Ajluni, supported by Commissioner Sandler that we accept the bylaws as presented and amended here today. Any discussion?

ALL: (No response)

MS. TURNER-BAILEY: All those in favor, please signify by raising your right hand.

ALL: (Affirmative response)

MS. TURNER-BAILEY: Opposed?

ALL: (No response)

MS. TURNER-BAILEY: It's unanimous. I would like to thank you, Mr. Styka, on the work that you did on getting these updated, also Commissioner Goldman, I know you worked with Mr. Styka on the changes to the bylaws. So I just want to thank you for your efforts in that regard.

MR. STYKA: And also Bill Hart; he helped with this, too.

MS. TURNER-BAILEY: Thank you, Mr. Hart, as well. Thank you. Next on the agenda, Cardiac Catheterization Services and Open-heart Services Volume Requirements, Update.

MR. HART: We have been -- after the meeting late on the -- in the December meeting, it was agreed that we should pull together a -- and following Dr. Bates' presentation about volumes on cardiac cath and open-heart surgery, we thought that there was sufficient questions that we should pull together a group to take a look at what these volumes -- the science behind the volumes and kind of where they came from and what they were purported to accomplish. And to do that, I'm pleased to announce that we have pulled together a meeting finally. And it wasn't an easy meeting to pull together because of the people we're talking about are for the most part physicians and schedules are hard. The schedule that we've been able to come up with is on the 15th of this month, hosted generously by Mark Mailloux and the folks over at U. of M. Hospital, from 1:00 to 4:00. And that meeting will be available on teleconferencing. We'll be speaking -- try to pull some information together on clarifying what these volumes really are; what they mean, the distance between Dr. Moscucci's way of doing business, Dr. Bates' way of doing business; we're going to be taking testimony, if you will, to come up with the science behind some of these volumes. And we have half a dozen or more physicians pulled together and other interested parties to share with us. Our physician, Dr. Eggleston, will be there and one of our policy analysts to pull together an issue paper that we can bring back to this Commission, to set down the points so a discussion could go forth. And perhaps this Commission would like to put together a SAC or whatever to address some of the things that Dr. Bates and Dr. Moscucci are talking about. So that will be next week. The phone number for dial-in will be available at the Department. We'll put it on the web page. And Mark announces that the -- since it's going to be happening over at the U Hospital, that the folks that want to participate should be there at 1:00 o'clock because I guess it's a maze to get through the facility. And we'd like to have everybody come at the same time so that they can be led through by one of his staff to be able to go to the meeting room.

MS. TURNER-BAILEY: Great. Thank you. You'll put that on the web, too, when you put the information --

MR. HART: Yes, it will. In fact, we should have that number by in the morning.

MS. TURNER-BAILEY: Okay. Commissioner Sandler? (Off the record interruption)

DR. SANDLER: Jan Christensen had discussed this with me afterwards, since I had raised some of the objections. Just to reiterate my concerns, because you have multiple level, you have a situation where you have one institution doing 273, but not in compliance, but another institution doing 205 or 210, that is in compliance. And there's something about this that doesn't make any sense. I mean, there's a lack of science here. Dr. Bates' point, however, was Dr. Prager, who's the chief of cardiovascular surgery at the U. of M., has assembled data on a number of issues here. And I would like to see the workgroup look at other things besides volume. Another item which all institutions have to have is mortality and morbidity outcomes. And that has to be a factor if you're setting standards; if an institution doing 500 has 4 or 5 percent while the national average in the United States is 2 percent, I'm not saying you take it away. What I am saying is perhaps they need to explain this to us. There's a whole issue here of patient safety that we need to look at in this -- I was asked to attend, but I'm going to be out of town. But I can attend by phone; we discussed that. But there's a whole issue here that needs to be looked at, other than simply volume. There is going to be some difficulty in establishing volume, because the ACC guidelines we looked up last time actually doesn't give a number for volume. And Bates actually claims there is no such number. We may have to look at that a little more carefully. There probably is a number based on experience, however.

MS. TURNER-BAILEY: Commissioner Hagenow?

MS. HAGENOW: I think it's now three years since the legislature said that we ought to be into not just setting the standards but to hold accountability to those standards. And I think it's good that something's really starting on this now. But I think we really need to sort of set it out in terms of a time line by which we're going to hold that accountability. Because it's -- again, to me the whole issue three years ago was the credibility of the CON. And I would just -- I guess -- say let's really keep it moving. Because I can see that we can argue about quality a lot, and I'm as concerned about the fact that we're not doing anything.

MS. TURNER-BAILEY: Commissioner Deremo?

MS. DEREMO: I would like to reiterate that we make sure that the discussion is not necessarily around how many procedures a specific cardiovascular surgeon needs to do, but really how many procedures needs to

occur in the facility in order to keep the facility up to standard and quality. And those are two separate issues. They are related, but they're two separate issues. And you could have one cardiovascular surgeon that is working in two different hospitals, but each of those hospital's volumes is not large enough for the staff within those hospitals to maintain competency. And so as we look at the issues of quality, I think we really have to look at it around the organizational competency and quality, not the cardiovascular surgeon. Because that's not why we're here is to monitor the quality of the cardiovascular surgeon.

MS. TURNER-BAILEY: Mr. Christensen?

MR. CHRISTENSEN: I just wanted to clarify the understanding that we had as a department based on the comments that were made at the December meeting, was that it was our charge, being asked by the Commission, to pull together a number of people who, by history, background, education and experience, were deemed to be experts in this arena, even though they likely won't agree with each other on all issues, but to bring them together to try and dig up the extent of the science that they had, and to have an open discussion on that just from that point; and then to bring that back to the Commission in some type of summary form so you would have at your hands what the science says and what it doesn't say. Any decisions about that going forward beyond that is the choice of the Commission. You could form a work group, you could form a SAC, you could make a charge, you could choose to delay it for a year and look at it again in a year; a variety of different options you could take. But from our point of view, we don't perceive ourselves as recommending a course of action but rather gathering the best scientific thinking that there is in the state from all of the quarters that have strong opinions and have data to share with us on this. And as a result, this meeting is actually quite small. There are seven -- or eight, nine physicians from the various arenas that have experience with this. There are people that have experience with the Leapfrog group and others; the Economic Alliance that have done studies on this. So we want to look at the science of it, and we'll bring it back. I can't predict what it will say or what it won't say, because really, we want to learn and bring that information back so that you have that at your hands. On the enforcement side, the point you raised, Norma, we're moving ahead with enforcement under the current standards and Mr. Wheeler will have a presentation about the current status of that in a few minutes on your agenda here.

MS. HAGENOW: Very good. I was --

MR. CHRISTENSEN: That's not stopping anything; we're moving on the current standards.

MS. HAGENOW: That's my misunderstanding. I thought that meant that that was deferred until then.

MS. TURNER-BAILEY: Commissioner Deremo?

MS. DEREMO: What is the process from the Department's perspective? Because I certainly respect that we'll have some top cardiovascular surgeons at this meeting. But knowing how organizations function, it frequently is the director of the operating room and the ability to keep the number of profusionists and all of those other issues that are -- that surgeons may know some of that, but from an administrative perspective, that would be under a different kind of track. How are we going to be capturing that kind of data and that kind of input, which is really related to the facility competency? Which as I said, again, I'm pushing back on this issue because they are connected but different.

MR. CHRISTENSEN: I think our task was to look at anything that's published peer review literature that's out there; whether it comes from system design and organization or facilities, or published in the national literature, the medical journals about outcomes. And we hope to look at all that. And we're hoping that the group we've pulled together, because of the breadth that's there, will have a familiarity with that research. But if it appears that it's not, we won't be uncomfortable in saying we haven't got the answer yet and we need to look father.

MS. DEREMO: Thank you.

MS. TURNER-BAILEY: Any other questions? Comments? Thank you, Mr. Hart.

MS. TURNER-BAILEY: New medical technology?

MS. ROGERS: Nothing to report.

MS. TURNER-BAILEY: Okay. Thank you. At this point I would like to ask the Commission's indulgence relative to the agenda. We have a couple people that are under time constraints, and we have election of officers listed later on in the -- much later on in the agenda. I would like to move that up so that we make sure everyone has an opportunity to participate. I think we can do that by consensus. So if somebody has some grave problem with that, let me know now. Otherwise I'm going to move to election of officers. Is that okay?

ALL: (Affirmative response)

MS. TURNER-BAILEY: All right. The first officer that we need to replace is the chairperson -- office of chair. At this time I will accept nominations for the office of chair.

DR. SANDLER: I nominate Commissioner Hagenow.

MS. TURNER-BAILEY: Commissioner Hagenow has been nominated for the position of chairperson. Are there any other nominations?

ALL: (No response)

MS. TURNER-BAILEY: Are there any other nominations?

ALL: (No response)

MS. TURNER-BAILEY: Any other nominations?

ALL: (No response)

MS. TURNER-BAILEY: Hearing none, nominations are closed. At this time I would like to ask for a vote for Commissioner Hagenow as the new chairperson of Certificate of Need Commission. All those in favor, please signify by raising your right hand.

ALL: (Affirmative response) (Off the record interruption)

MS. TURNER-BAILEY: Thank you. That's unanimous. Congratulations. Would you like to make a speech of some sort?

MS. HAGENOW: No. I still feel like a novice. And sitting at your right hand for one year is not very long. I'll give it my best.

MS. TURNER-BAILEY: We're looking forward to it. At this time I would accept nominations for the position of vice-chair.

MR. DELANEY: Commissioner Delaney nominates Commissioner Goldman as vice-chair.

MS. TURNER-BAILEY: Commissioner Goldman has been nominated as the new vice-chair of the Commission. Are there any other nominations? Commissioner Ajluni?

DR. AJLUNI: Commissioner Ajluni nominates Dr. Michael Sandler for vice-chair.

MS. TURNER-BAILEY: Commissioner Sandler has been nominated as vice-chair of the Commission. Are there any other nominations?

ALL: (No response)

MS. TURNER-BAILEY: Are there any other nominations?

ALL: (No response)

MS. TURNER-BAILEY: Any other nominations?

ALL: (No response)

MS. TURNER-BAILEY: Hearing none, the nominations are closed. We have as candidates for vice-chair of the Commission, Commissioner Goldman and Commissioner Sandler. Those who --

MR. ANDRZEJEWSKI: Renee?

MS. TURNER-BAILEY: Yes?

MR. ANDRZEJEWSKI: Is it possible to vote by written ballot rather than raising hands?

MS. TURNER-BAILEY: I will defer that to our counsel.

MR. STYKA: Under the Open Meetings Act, the short answer is "no."

MS. TURNER-BAILEY: Commissioner Andrzejewski?

MR. ANDRZEJEWSKI: I have another suggestion which may meet the provisions of the Open Meetings Act. And that is if Dr Sandler and Mr. Goldman vote for themselves, they can be excused. And the rest of us can vote for the -- one of the two parties.

MR. STYKA: Well, you can't require them to be excused. If they want to leave the room, that's up to them. But they can't vote when they're out of the room --

MR. ANDRZEJEWSKI: That's a suggestion and if they vote for themselves --

MR. STYKA: -- and you could end up with a problem on your numbers.

MR. ANDRZEJEWSKI: If they vote for themselves in front of an open forum at a public meeting, after they vote for themselves, they can be excused and then the rest of us can vote for Dr. Sandler or Mr. Goldman.

MR. STYKA: Well, under an Open Meetings Act, all deliberations and votes are public. And there's going to be a public record. So the vote's going to be known no matter what. So I'm not sure if that makes any sense, but if they want to leave, it's up to them. But they can't vote while they're out of the room.

MS. TURNER-BAILEY: Okay. I'm sensing a reluctance for anyone to leave the room so we're going to go ahead and --

DR. SANDLER: If Ed feels --

MS. TURNER-BAILEY: Those who wish to cast their vote for Commissioner Goldman as vice-chair, please raise your right hands. Turner-Bailey, Hagenow, Deremo, Maitland, Delaney, Andrzejewski, Cory and Goldman: (Affirmative response.}

MS. TURNER-BAILEY: Eight. Those who wish to cast their vote for Commissioner Sandler, please raise your right hand. Young, Ajluni, and Sandler: (Affirmative response.)

MS. TURNER-BAILEY: Eight to three, so the new vice- chair would be Commissioner Goldman. Congratulations. (Off the record interruption)

MS. TURNER-BAILEY: Now, I assume that means that I should finish this meeting?

MR. STYKA: (Nodding head in affirmative).

MS. TURNER-BAILEY: Okay. Thank you for your indulgence and a change in the agenda.

MR. STYKA: Yeah; that's pretty much custom as to which way you want to do it, whether you turn it over now or finish the meeting. I think traditionally, this Commission has always finished the meeting.

MS. TURNER-BAILEY: Okay. That's fine. Next on the agenda is the compliance report. We have Mr. Christensen and Mr. Wheeler.

MR. CHRISTENSEN: Actually, you have Walt Wheeler on the compliance report. I beg the apologies of the Commission, but I have another meeting that I cannot miss.

(Mr. Christensen leaves room)

MR. WHEELER: Members of the Commission, good afternoon. I'm Walt Wheeler. I'm the director of the Bureau of Health Systems, which does the enforcement of all this. And it was a good, I think, discussion you had on open-heart, because some of what I'm going to be talking about this afternoon deals with what we're doing in that area. We have six ongoing enforcement actions right now; five of them relate to open-heart. And each one of those institutions that we've identified from our audits as having some deficient volume with respect to the standards that apply to them. In each case, we are undertaking several steps. First of all, we sent them a letter and announced formally that we are instituting an investigation, asked for contacts, and asked them some preliminary questions to determine whether the issues with their program is strictly volume or if there are other terms and conditions of approval that might be involved. We did start and are in the middle of -- actually finishing up a program audit of each of those programs. And that audit deals with all of the conditions and terms and asks them to go through each of those to describe what the status of their program is and how that relates to the requirements for approval that they were approved under. We've asked and conducted face-to-face meetings with the executives, and then sometimes the attorneys of each of the institutions, talking about our concerns and their responses to our audits. And we've now requested and got an assigned Assistant Attorney General to help represent us if legal issues come up. As I speak, in each case we are hopeful to offer and come to a voluntary resolution of this which would allow these programs to come into compliance or terminate their program with a date certain, on the assumption that all the other conditions and terms of approval are in compliance. And we believe that for the most part these issues are strictly dealing with the volumes of the programs. And that's basically the status of our five actions dealing with open-heart. We have another enforcement issue that deals with mobile MRI's. And here I would just like to say publicly that if a facility has a fixed MRI and that MRI goes broke and becomes inoperable for whatever reason, they must contact us for an emergency Certificate of Need before they bring in a mobile MRI to fill the gap. We will commit to going quickly, but we cannot have situations where you have mobile MRI's or replacement MRI's or any other type of covered equipment that's brought in without us knowing about it. And if somebody does do that, they're going to be facing some kind of response from us. And in this situation, we are looking to see what to do about the period of time when the unauthorized piece of equipment was brought in and the time we issued the emergency Certificate of Need. And, again, we'll be talking to them. This is a much more preliminary right now, but we will be doing something in -- to respond to that issue as well. In the future, once these things are well under way, we're probably going to undertake some more in-depth audits of transplantation services as our next area of focus, although we will be responding to other problems as they are brought to our attention through whatever means there are. And that's basically it. I'm open for any questions from the Commission.

MS. TURNER-BAILEY: Commissioner Hagenow?

MS. HAGENOW: I'm wondering about that time line. What is -- what's the due process, basically, in terms -- you said you'd be issuing a time line or a due date kind of thing. What does that mean?

MR. WHEELER: Well, we will -- we're yet to see if we can come to some terms with each of these institutions as to what would be a mutually acceptable time frame for them to come into compliance or terminate the program. And we're -- we haven't had the second meetings with that, and we'll be having our AG with us. So I can't really say about that at this point.

MS. HAGENOW: I'm just wondering if it shouldn't be sort of a due process like you do with a -- this may be overly simplified, but with an employee, that you state in advance what the due process time line is. Because if it's very open-ended, it could be --

MR. WHEELER: I understand what you're saying. There will be a date certain. It won't be open-ended.

MS. HAGENOW: Okay.

MR. WHEELER: They'll either make it by that date or stop. And we might give them, you know, a certain little bit of time after that time to wind it down, but that -- there will be a date certain and we will know at the start of this what it is.

MS. TURNER-BAILEY: Are there any other questions?

ALL: (No response)

MS. TURNER-BAILEY: Thank you.

MR. WHEELER: Thank you very much.

MS. TURNER-BAILEY: Legislative report?

MR. STYKA: Before you go, there is sort of a corollary -- another area Walt didn't mention, and I think it's reflected in the legal action report you have that we give you each meeting. The Department took strong action against the development of a facility of various kinds, all in one location, in Clinton called Clinton Diagnostic Center in Macomb County. And this was a place that was purporting to have MRI's, CT's, PET, surgery suite and even has bought another piece of land where word was they were going to build a hospital. They're connected with a Native American tribe, and the Department took strong action to inform them that they had to go through the CON process. And, in fact, after numerous communications from both the Department and the Attorney General's office, they finally relented and are now in the CON process. We don't know that they'll qualify; I mean, that's up to the -- it will depend on the standards and needs, et cetera. But they're now -- they've actually now filed letters of intent to do the CON process.

MS. TURNER-BAILEY: Excellent.

MR. STYKA: The other thing I wanted to mention is that -- that might be of interest is this Commission has spent many, many meetings in the past dealing with the whole issue of whether or not some of the beds from Detroit hospitals should be moved to West Bloomfield and Novi in accordance with Act 619, the amendatory act, that, as you know, has been in litigation. And next Tuesday, March 15th, I will be arguing that in the Court of Appeals. So we will be moving further along. So far, the courts have been saying it's okay to do it, so we'll see what happens.

MS. TURNER-BAILEY: Thank you. You know, it's interesting you said we usually get a legal action report. But I don't know that we -- do we? Is it here?

MS. ROGERS: It's in the binder.

MS. TURNER-BAILEY: Is it --

MS. ROGERS: It's titled "CON Legal Activities."

MS. TURNER-BAILEY: Okay. Yes, I knew that. Thank you. Legislative report. I see it's in there, but we don't always go through it publicly.

MR. STYKA: No, but since you were doing the other kinds of enforcement, that relates, too. I mean, that's also proof to the legislature that your laws are being enforced.

MS. TURNER-BAILEY: Sure. So we might want to sort of do that every time, if there's anything --

MR. STYKA: I mean, there's other things on the list. I just --

MS. ROGERS: In your packet, you do have a copy of Senate Bill 576, otherwise known as Act Number 469 that was passed. And this bill increased the Certificate of Need fees. I don't have the exact dollar amounts with me, but if you'll look at the bill, it changes the base fee to $1500 for each application, and it adds $4,000 for the next level, and then it adds $7,000 to the base fee for the third level.

MS. TURNER-BAILEY: What tab is that?

MS. ROGERS: That is under "Legislative Report." And then the other item that we just passed out after lunch, and we've been in contact with Renee, is the Commission is required to submit a letter to the joint legislative committee in January of '05 and then every two years thereafter. This was brought up at the December meeting. So what you have in front of you is a draft memorandum that we've prepared. And, Renee, I'm going to leave it up to you as far as how you want it handled, looking at this letter.

MS. TURNER-BAILEY: Well, I don't know --

MS. ROGERS: And just to let you know, it's based on the previous letter. And then what we tried to incorporate is some of the accomplishments the Commission's had over the last, I think it's two years.

MS. TURNER-BAILEY: I would like to get this letter approved if possible, today, so we could send it out. I know people have not had a lot of opportunity to read it, so maybe if we could just take a few minutes and look through it, tell us if you have any grave concerns and we can make those changes even after we all sign the signature page here. So if we could just take a few minutes to do that. I apologize for asking you to do this. It essentially lays out some of the accomplishments that we've made over the last few years. Brenda, do you have an original for us --

MS. ROGERS: Yes.

MS. TURNER-BAILEY: -- to sign, if it's the will of the Commission?

MS. ROGERS: Yes.

MS. TURNER-BAILEY: Commissioner Hagenow?

MS. HAGENOW: It seems to very well address the things we have done. It doesn't say anything about this enforcement thing, that it is active and alive and so on. And it seems like in the original -- as I mentioned before, in the original legislation, there was -- we were to both become active and have a sense of urgency and make things happen, but we also were to uphold the accountability to the enforcement of the standards. And I just wonder, since that is an active process, whether that should be noted.

MR. HORVATH: Yeah; we -- in the second page, second bullet to the bottom -- it's probably not as descriptive as you would like, so we could -- what we have done is designed this letter for the third page to be actually the signature page. That way if you made edits to the first two pages and approved those edits today, we would go back and make those edits and we'd still have your signatures ready.

(Mr. Styka leaves room)

MS. TURNER-BAILEY: Well, and I think to Commissioner Hagenow's point, we could strengthen that bullet quite a bit. Because as we've just heard from the report we received a few minutes ago, there is quite a bit of activity along those lines. So maybe we might to just change that sentence. Maybe that's sort of something we can work on now before people leave. They can take a look at it before putting their signatures on it.

MR. HORVATH: Sure. If somebody has suggested language, we would go back --

MS. ROGERS: Make changes, --

MR. HORVATH: -- and finalize it.

MS. TURNER-BAILEY: Okay. Any other questions or comments or suggestions for edits?

MR. HORVATH: Just real quick, the first part, keep in mind is that your two-year reporting requirements, which took effect in PA 619, the first paragraph is saying that you're not recommending them to take any action to revamp the program. We do have in this letter -- the 2003 report is included in your package, activity report that we prepare for you every year. The 2004 we were close to having done. But unfortunately, due to the flurry of activities -- last minute activities, we had to shift staff away from the report to finish up for the Commission meeting. That is basically done. What we will do is give the final version in e-mail to the commissioners before it actually goes to the legislature.

MS. TURNER-BAILEY: Okay. Any questions?

MR. MAITLAND: Since Mr. Delaney had to sit through this meeting you should have his signature line there, but --

MR. HORVATH: I'm sorry.

MS. ROGERS: We missed it.

MS. TURNER-BAILEY: So is there a way to edit that?

MR. HORVATH: (Nodding head in affirmative)

MS. TURNER-BAILEY: Good point. So if you have to leave before the meeting is over, please --

MR. HORVATH: Actually, we're a little bit off kilter here. We did have Commissioner Delaney on the shortened version of the letter, and in the rush -- we will have to remedy that.

MS. TURNER-BAILEY: Okay. The next item on the agenda, --

MR. GOLDMAN: Let me just make one fast suggestion. If you look at the document we've just been looking at, the March 8th, 2005, report from us to the joint legislative committee, and we wanted to do something on the second page, second bullet from the bottom -- (Off the record interruption)

MR. GOLDMAN: On the March 8th report, if we wanted to do something more on the second bullet up from the bottom of the page about adding a compliance report, this is a report from us to the legislature. So it's not a report about the Department's activities.

MS. TURNER-BAILEY: That's true.

MR. GOLDMAN: It's a report about our activities. So I think what we could say is that we added a compliance report agenda item in order to receive and monitor compliance action by the Department. We can't actually do the compliance action. But we could say receive and monitor, which is more active verbs.

MS. TURNER-BAILEY: I think that's a good suggestion. Because we don't have to get into the actuals -- the numbers or anything.

MR. GOLDMAN: No; because the Department can do that in their annual report.

MR. HORVATH: So "Added a compliance report agenda item to our regularly scheduled meetings to receive and monitor compliance action by the Department"?

MR. GOLDMAN: Yes.

MS. HAGENOW: I'd use the term hold accountability, and that says it much nicer, I think.

MR. HORVATH: Just to let you know we are sending two sheets around to get everybody's signatures, so then we will be able to do this. So if you sign a shorter letter, we'll be able to bring Commissioner Delaney into the hold better. So that's why we're having you sign twice. We'll use our technology to make that fix. (Off the record interruption)

MS. TURNER-BAILEY: So are there any other suggestions to the letter?

ALL: (No response)

MS. TURNER-BAILEY: I think that was an excellent suggestion. We should address Commissioner Hagenow's concern relative to our report to the legislature. Thank you very much. Annual Report. Is there -

MS. ROGERS: In your packet, you do have the 2003 annual report. Sorry for the delay; we do apologize. As Larry mentioned, the 2004 report is just about finalized. We are anticipating here within the next week to be able to e-mail that out to the commissioners. So that way both reports will be available to be submitted with your letter to the joint legislative committee. I apologize for not having time to go through and point out some highlights. There is something that I do want to mention. With the recent fee bill that was passed, in fiscal year 2003, the fees that we were bringing in were not in compliance with the cost to the program. So now that the fee bill has passed, hopefully that -- those things will change and we will be in compliance with that. So that's the one major thing that does stand out and you'll see that as you go through it. As you go through, if you have questions, feel free to contact us or bring your questions back to the next meeting if you want to. But we are available. And like I said, pretty much the same report as we've given you over the years. We are in the process of trying to add some new things; make some changes over the next hopefully year or so to maybe have some better things that we can monitor and include in the report.

MR. HORVATH: The one thing I would add to that is the reason we're going to try to revamp this report is part of the Inspector General's audit and requesting that we find measurements to measure the effectiveness of the program. So we are looking at this. The other thing that we are putting in our program goals is to have this report to you at your first quarterly meeting of each year. We almost made it on 2004, just got a little bit behind.

MS. TURNER-BAILEY: Thank you. Any questions?

ALL: (No response)

MS. TURNER-BAILEY: Audit follow-up?

MR. HART: Yes. You will recall the Auditor General's report -- I have a copy here -- April 2002, there were five findings in that report. Three of them are identified as material findings. We just met with the Auditor General staff, Rich Stafford and Bryan Weiler, to begin the follow- up of this audit. It's a standard follow-up review. They will be looking at the material findings. Those are the items 1, 3, and 5. And you've been discussing some of those this morning. The first finding was the evaluation of the Certificate of Need program. The second material finding was the monitoring of approved CON projects as they're underway, and the third was the monitoring of CON projects and the review standards. What I have here to my left is one of the reasons that Larry didn't -- missed it by a day with his annual report. This is what they've put together so far in response to the Auditor. So we'll be meeting with the auditors here in the next week or two, to begin looking at these issues. Larry thought he'd pull a few things together, so we have one of these for Bryan. The -- a report will be issued on the findings and that report will go out on the website. I was in contact with the auditors this morning, and asking them specifically about the input of the Certificate of Need Commission; that the Certificate of Need Commission was interested and commented in the last one, so that report will also be -- before it's released publicly, will be available a day or two in advance of that. And we'd be more than pleased to share that -- if they give it to us -- with the Commission. And so as soon as we get that, we'd be more than happy to -- if the commissioners are interested, before that gets put out publicly, we could offer a look at that --

those audit findings. This is not a legislatively driven audit request. It is a simple -- as it was identified from the supervisor there, a simple follow-up that's procedural in nature. We look to a written response from that. They'll be using audit memos as responses back and forth as we take a look at what they have to say. We think the fact that there's been a tremendous amount of progress that has been made, that the CON staff has been working diligently on the five findings that were there, and believe we've made great progress in all of those areas. So we're looking forward to the audit team coming in and taking another look at the findings that they developed. And if anyone needs a copy, by the way -- I don't know, perhaps some of the new commissioners don't have a copy of that 2002 audit, we could make that available, too.

MS. TURNER-BAILEY: Excellent. Thank you. Any questions?

ALL: (No response)

MS. TURNER-BAILEY: Thank you very much. Future meeting dates. Our next meeting will be June 22, 2005, followed by a meeting in September the 13th, and December 13th, 2005. So three more meetings, assuming we don't schedule any special meetings between now and the end of the year. If that becomes a problem for commissioners, let us know very, very far in advance. Not that we can probably do anything about it, but it's good to know. Public comment. I do have two cards. Larry Horowitz?

MR. HOROWITZ: Out of courtesy to the Commission since there's been much discussion today about open-heart surgery, I want to share with you that we will shortly be publishing our 10th anniversary publication of a listing of open-heart surgery volumes for each program in the state. And we still have some fine tuning to do it, but we'll have it out very shortly on our website and we'll make sure to alert each commissioner. I just had a useful -- since our data is more recent than the Department's data, they have their own internal required processes, we only have to worry about monitoring this particular item. So our data goes through the year 2003, which we have verified and confirmed. The State has 2003 data, but they have not yet finished their edit process. But I am confident enough to tell you what I think are some notable conclusions that I think speak centrally to the discussions that Commissioner Deremo and others had. In the year 2003, we had 14,525 open-heart surgeries in the state. That's just one more than the year before. What that really means is that the same number means there's a continuing decline. How can same be a decline? Because the Department expended the number of codes which are recognized as open-heart surgery this year. And the best estimate that Stan has is that average potentially increased the total volume by 20 percent. I don't think that's a hard number by Stan, but a rough estimate. But in any case, there is a more liberal count underlying the 2003 numbers than were underlying the 2002 numbers. So that confirms what has been a steady decline. Using the old formula, we had 15,813 in the year 2000. Open-heart surgery is declining. There's no particular surprise that people are knowledgeable about this; the use of medication, stents and so forth has resulted in less use of open-heart surgery. The question that arises, well, then, what do you do? If there are fewer than "x" being done, should you lower the criteria for how many "x" you have to do -- right? -- or not. We clearly think that this has been a great success story for Michigan in having the 300 minimum volume that's been in place for new programs since February of 1993. It has constrained the proliferation of programs. It has meant that you're not having more and more -- there have been some new programs, no question about it, but relatively few. There have been about six under the new standards, that -- what it means is that you're not having more programs dividing up a declining volume. If you keep having more programs cutting up a declining volume, even fourth-grade arithmetic tells you you're going to have a lower average volume. Lower average volume, by all the studies they're looking at -- people can debate what the precise number is -- but there's certainly very good and hard evidence that the more you do of certain risky procedures, the better off you are. Now, clearly the overall curve has gotten better in 20 years. The mortality rate associated with open-heart surgery has declined. It's now running, or it used to average nationwide, if it could be 5, 10 percent when we began this effort; it's now more like 2 percent. But there are some programs that are running less than 1. And of course, you can say well, you either look upon this as no big deal; what difference does it make between 98 and 99 percent chance of survival; on the other hand, you might look upon this more as is there a difference in your judgment between a 1 and 2 percent chance of your dying. Right? It depends how you look at life. But I think most people, when it comes to dying, would really be very focused on even small numbers. To give you a kind of example, there are 32 adult programs in the state. That means we used to have an average of 500 cases per program. Based on the most recent year, we're now down to 454, again, with an inflated definition of what the numbers are. We would strongly urge -- and we're certainly going to be there and glad that we're participating in this process with folks -- that we would continue to support the American

College of Cardiology recommendation on facility volume, the point Commissioner Deremo makes for open-heart surgery, where the still current recommendation of the College is a minimum of 2- to 300 for facility volume for open-heart surgery. Now, then it's up to the Commission to make a judgment; where do you think Michigan should fall in between that interval of 2- to 300? Your colleagues in December of '92 made the judgment that in observing the College's recommendations that they would allow that variance for considerations of widely dispersed, sparsely settled populations. That's why they gave that variance. Frankly, the commissioners before you made the judgment that Michigan is more of a populated state and is not comparable to Montana and Idaho. The other thing we've gotten out of this program is that it's a very good geographic distribution. So we just wanted to -- since this is a hot item and people are talking about it, I didn't want to be in the position that we didn't share with you our best information at the point of this meeting and wait until next June. But we should have finalized copies for that discussion next week. Thank you very much.

MS. TURNER-BAILEY: Commissioner Sandler?

DR. SANDLER: Yeah; I have several comments. I think it's great that the Economic Alliance is publishing this material. I have several comments. One is, do you also publish mortality figures?

MR. HOROWITZ: (Shaking head negatively)

DR. SANDLER: No?

MR. HOROWITZ: There are no mortality figures accepted by the medical profession, even rough mortality numbers; not to mention I think everyone would agree, that they should be severity adjusted to be a meaningful indicator.

DR. SANDLER: Doesn't each institution, Stan, know this number?

MR. NASH: I don't think so.

DR. SANDLER: Okay. Point two.

MR. HOROWITZ: But, Dr. Sandler, I can't help -- when we did this survey at the beginning of our effort, we discovered the anomaly that 75 percent of the open- heart surgery programs had better than an average mortality rate, which my statistics professor told me that that was a basic flaw. If what you have is individual entities who develop and determine their own quality standards, their own outcome measures to determine death on -- at the end of the operation, thirty days later, 100 -- two months later, six months later, there is no standardized data. If there were, we'd much prefer using it.

DR. SANDLER: But I thought you just said they recommend 200 to 300? Who recommends 200 to 300?

MR. HOROWITZ: Doctor, I'd be glad to -- we will --

DR. SANDLER: I'd be delighted. I e-mailed Dr. Eagle in Ann Arbor who is the lead author of about 10 cardiologists and he didn't have a number. What he said in his e-mail back, what I distributed was his personal recommendation. And Bates said that's just his opinion. But you need at least two surgeons. Therefore a facility should have at least 200. But Dr. Bates immediately said, "Well, that's nice, but that's only Kim Eagle's opinion."

MR. HOROWITZ: Dr. Sandler, I discussed this with Dr. Eagle.

DR. SANDLER: Good.

MR. HOROWITZ: And he had -- I can give you the answer. Dr. Bates was not here before you, never participated in the discussion about open-heart surgery. He is, after all, representative of cardiologists. What he was speaking to was the volumes for cardiac catheterization, specifically the cardiologists' minimums.

DR. SANDLER: No; no. He specifically commented on the number for --

MR. HOROWITZ: In order to clarify this, he came and spent an hour with our committee and we went through this in great deal. And he was very specific in telling us that because it was confusing in this form, that he was not addressing the issue of open-heart surgery. He felt that was outside his domain of competence and knowledge, and the role of the American College -- and the cardiologists.

DR. SANDLER: But I thought you just said they recommend 200 to 300? Who recommends 200 to 300?

MR. HOROWITZ: The joint entity made up of the American Heart Association -- right? -- and a cardiac surgery group -- I can't tell you their right name -- have a joint recommendation that dates back to the -- on the minimum facility for open-heart surgery. Dr. Bates was very clear, saying, "Listen, cardiologists don't do surgery." They don't do open-heart surgery.

DR. SANDLER: Oh, yeah; we know. Fortunately.

MR. HOROWITZ: Right. Well, then -- so he was very strong on telling our committee because we wanted to hear ostensibly, his discussion, he was just speaking to the question of cardiac catheterization, both angio- -- both therapeutic and diagnostic. So I'm trying -- I'm up here particularly to make the distinction that Dr. Bates has been here two, three times talking about cardiac catheterization, running these catheters up the veins, checking --

DR. SANDLER: I realize all that. But he specifically commented on the volume for bypass when he was here.

MR. HOROWITZ: I heard you talk about it, Doctor.

DR. SANDLER: Well, no; now don't --

MR. HOROWITZ: I found it very confusing; that's part of the reason why we invited Eric to come with us and he shared that information with us.

MS. TURNER-BAILEY: Commissioner Deremo?

MR. HOROWITZ: He didn't speak to the minimum volume of open-heart surgery.

DR. SANDLER: Well, he did at the last meeting here. Now, he also -- it's also Bates' opinion. He also said that.

MS. TURNER-BAILEY: Commissioner Deremo?

MS. DEREMO: Just when we get into the issues of quality, we need to be very careful about mortality because straight mortality does not do severity adjustment. And one program might the sickest of the sick, and another program might not have very ill open-heart surgery patients. And so -- I mean, I think as we think we get into this quality discussion and the issues of mortality, we really to make sure that we're comparing apples to apples.

MR. HOROWITZ: Commissioner, that's precisely the judgment we've made each year for 10, 12 years, why we have not published it. If there was a generally accepted severity-adjusted method for making these judgments, we think that would be good. But there does not appear to be that judgment in the profession.

MS. TURNER-BAILEY: Commissioner Goldman?

MR. GOLDMAN: What my concern is, is that I think there is a change in the way cardiac care is being delivered. There is less need for cardiothoracic surgery because there is more ability for cardiologists who don't do surgery but do do an invasive procedure, including use of angioplasty and placement of stents. And there are better medications. You put all that together, what I'm interested in seeing from the kind of data that we're trying to collect is, are the total number of cardiothoracic surgeries and the need for cardiothoracic

surgeries going down overall? And, if so, what's a safe bottom? Because in general the medical literature does suggest that the more you do a difficult task, the better you get at it; and the better you get at it, the less side effects you have. Now, Commissioner Deremo's exactly right. You can't measure side effects in a gross way. The first time the Federal government attempted to look at mortality, they had one hospital that had shocking mortality and it turned out to be a hospice. So you have to look at that -- you have to look at what you're measuring in order to be able to measure it correctly. And I think that is a tricky thing. But my concern is, if I'm right, that overall cardiothoracic surgery is going down, and the numbers in Michigan seem to indicate that, then we do need to see where a safe floor is and we have to look at -- those numbers are going down and cardiology numbers are going up, then we have to look at safety there. And maybe we -- maybe there's things in the literature about infection control; maybe there's things in the literature about 30- day return to surgery or side effects. But I don't know. But that's what I'm looking for from the reports.

DR. SANDLER: Let me comment. There's no question it's going down. And most of it is due to new stent introduction and angioplasty. Probably stent is a little new, so they're finally making a small dent; in 10 years from now, probably will make a major dent. The other problem which this workgroup has to address is the following: It's my understanding if you don't have cardiac surgery, you cannot do interventional cardiology on an elective basis. Isn't that correct?

MR. HOROWITZ: Correct.

DR. SANDLER: An elective basis, you cannot offer that service.

MR. HOROWITZ: You can't do angioplasty without onsite backup.

DR. SANDLER: And that makes a huge difference to outlying communities, the fact that they cannot offer a service now that is pretty routine both in Michigan and the United States. And they're going to have to be transferred -- what you're going to be doing is a diagnostic cath at Hospital A then transferred to Hospital B and repeated for an angioplasty, although diagnostic CAT's really on the way out because of CT and arteriography anyway. But this -- there's a whole host of issues is the point I'm trying to make. And the loss of interventional cardiology to a institution is really a major loss.

MR. HOROWITZ: Dr. Sandler, I just want to point out that we're not talking about the loss of interventional cardiology. No one is now doing interventional cardiology unless they have open-heart surgery, as you just said, so that the question is do you now want to expand the number of places doing angioplasty? Now, this, to us, is a question -- not a question of access and cost and everything else. What we find with great interest is that the way that the Commission has set this up, there's a very good geographic distribution of places that do open-heart surgery and angioplasty combined. There is no geographic area in the state that is -- that does not have such a center with significant volume within an hour's distance. That's a pretty good -- that's a pretty good record in Michigan.

DR. SANDLER: I don't want to prolong this elegy, but let me make a final statement. I agree with, frankly, the bulk of what you've said. The concern would be this -- the first concern is obviously patient safety. But at some point you have to realize if you're taking away cardiac -- we're not going to add anything. But if you're taking away cardiac programs from major institutions, that's a major loss to that institution.

MR. HOROWITZ: But you're not taking anything away.

DR. SANDLER: Well, they have it now, they don't comply, the numbers fell, you take it away. That's the scenario I'm looking at.

MR. HOROWITZ: So you're talking about the compliance; whether we should enforce our current rules?

DR. SANDLER: Correct. Now, once you've done that -- and maybe that's the appropriate thing to do. I'm not saying it isn't. But once you've done that, then you're taking away interventional cardiology from that same medical community. Then the cardiologists had better move elsewhere, so on and so forth. My only point is, there are a lot of ramifications of what we're thinking of doing. That's the only point I'm trying to make. And we need to look at this judiciously, patient safety versus patient access.

MR. HORVATH: Renee, can I just --

MS. TURNER-BAILEY: Sure.

MR. HORVATH: One point of clarification is the Commission did pass, so emergency angioplasty is available.

DR. SANDLER: Yeah; we know. But most angioplasties do not -- those emergency angioplasty patients are patients with heart attacks. What? -- 95 percent of people getting angioplasties haven't had a heart attack? 90 percent? Some number like that; it must some number like that. All I'm saying is before this Commission makes any decision, we better be judicious of what -- the ramifications of the decision is the only point I'm making.

MS. TURNER-BAILEY: Commissioner Hagenow?

MS. HAGENOW: I thinking of the focus of the CON and how big and wide and deep it is in relation to quality. I mean, access and some other things seem to me to be easier because the world out there hasn't decided on quality except in things like volume. But if you go to the Institute of Health Care Improvement, the largest factor to reduce preventable mortality is whether the doctors make -- and the whole team makes multi-disciplinary rounds. So we're talking about issues that are vast and big that are happening in terms of what will change quality, and it's not necessarily issues that the CON -- I think we could get bogged in a real deep hole here, and there's a whole world of people working on that. So I would really want to analyze our focus as then how far and deep we go.

MR. HOROWITZ: Just -- now in conclusion, I totally agree with Dr. Sandler. This involves a tremendously wide array of issues than just some particular literature search. I noticed that since he's focused on the issue of enforcement, of the five programs that Mr. Wheeler mentioned, four of them are at hospitals which are right in the middle of communities of lots of different cardiac programs. And the only one that is even far out is the one that's probably going to be in the easiest compliance. So I don't think, Dr Sandler, that the Department enforcing the rules that everyone else has lived up to does bring you much exposure on losing access in communities.

DR. SANDLER: I agree with that; I do.

MR. HOROWITZ: Thank you.

MS. TURNER-BAILEY: Lynn Bosscher?

MS. BOSSCHER: My name is Lynn Bosscher and I'm here representing Spectrum Health. And in this case, I am speaking on the Alliance for Health, as Lody is absent right now. I'm here to speak about the issue of removing the bed inventories from the standards as previously discussed. And as we now, all communication from the Department requires a FOIA request. And in the case of the bed inventories, we would ask that the inventories not require a FOIA request from the Department. We acknowledge that the Department has many requests and is often bogged down by these. And by removing the inventories, it creates a barrier to those who are trying to view the standards as a whole. At a minimum we would ask that the bed inventories not require a FOIA request, and we would hope that they would be placed on the web for all to view. Thank you.

MS. TURNER-BAILEY: Thank you. Any questions?

ALL: (No response)

MS. TURNER-BAILEY: Any comments? Can we commit to that now?

MR. HORVATH: We have been working hard to post them onto the web. The only reason we ask for a FOIA request is because administratively, it's helpful to show the volume of work that the program does. We have hundreds -- we account for 70 percent of the central office FOIA requests inside the Department. So we devote a lot of staff to making copies of applications and everything. But we are working hard so the

inventories are out there 24/7. Joette, our inventory person, has been working hard to get them ready. We hope -- we have said this for six months or so, but we hope soon we will launch psych first, nursing homes second, and then hospital beds will be the third inventory out. But we do agree with that.

MS. TURNER-BAILEY: Okay. Thank you. Commissioner Goldman?

MR. GOLDMAN: I just had a quick comment. If you look in our book under the tab "CON FOIA Request Report," you'll see a number of pages. I don't know that they're consecutively numbered. And I just wonder, with this kind of volume that we see every quarter, whether there is an opportunity for us, Larry, to look at this, figure out the top ten repetitive requests and think about whether those are things we can kind of put on the -- it would save us time and it would save us money over the -- not even the long run, over the short run probably.

MR. HORVATH: I agree with that. That's a good thing. We'll go back and look at it.

MR. GOLDMAN: Thank you.

MS. TURNER-BAILEY: That was an excellent suggestion. I don't have any more cards for public comment. So I'll move on to the review of the work plan. Brenda?

MS. ROGERS: We'll go down through here and then we can add or delete if I miss something. Hospital beds will remain on the work plan. We have language moving forward for a public hearing, so we will be scheduling that. MRT remains on the work plan. Just to let you know, that committee is working and they are progressing. They have another meeting scheduled for next week, on Wednesday which I believe is the 16th. Open-heart surgery was added at the December Commission meeting. That remains on the work plan. PET remains on the work plan. Psych remains on the work plan, and you took action today, so we will be preparing language and scheduling a public hearing. Surgical services, we've received the nominations and we are in the process of going through those and getting the list to Norma and Ed. So once we have those compiled, hopefully in the next week or so to select that committee. Tentatively, depending on if we meet all the numbers, et cetera, we've got a tentative meeting, I think, scheduled for April 22nd, I believe, for the first surgical meeting.

MS. HAGENOW: Could I have the names, even those that you do have, so that I could start reviewing it and thinking about it? I know that when it comes all at one time, it's really hard. I don't know. I think you do a good job of it, but I would like to see what we have and start noodling through it, if I could.

MS. ROGERS: We can certainly get the copies of everything made, I just don't have the list to go along with it. So I can do it either way.

MS. HAGENOW: Just to help you, because it's kind of hard to integrate it in one phone or one meeting.

MS. ROGERS: Okay. Next item, new medical technology remains on the work plan. The 619 sections requiring Commission action and the one that was in your binder today had a couple of updates as a result of some action taking place today. There will be a couple of more updates on that list. CON annual report will -- we will remove since that has been presented to you, and the 2004, as I stated earlier, sometime in the next week, we will be e-mailing that to you as well. And then the legislative report, you finalized that today. We'll make the suggested changes, get that out to you, and then we will forward that onto the joint legislative committee so then that can come off the work plan. MRI, you took action today, so that's added to the work plan. And we will be scheduling, again, public hearing for language for that. Bone marrow transplant is added to the work plan as a result of your action today. And, again, we will be scheduling public hearing for that.

MS. TURNER-BAILEY: Any questions?

ALL: (No response)

MS. TURNER-BAILEY: Lynn Bosscher?

MS. BOSSCHER: Hello again, my name is Lynn Bosscher, and this time I will be representing Spectrum Health in Grand Rapids, Michigan. Our organization recently assessed the PET standards and as a result of this review, we believe the PET standard should be open soon. We believe the important issue of relocation needs to be addressed. Currently the relocation of a PET scanner is not permitted under the standards, because PET technology has become a standard in cancer treatment and diagnosis. PET use is expected to grow significantly. As a result, Spectrum Health believes the standards need to be revised to give the service more flexibility in relocating. All other standards for equipment, MRI, CT, MRT, et cetera, address relocation, and we feel that PET standards should as well. The issue of the PET standards can be best addressed by forming a Standard Advisory Committee and this would allow a SAC to discuss the specifics. And therefore we urge the Commission to form a SAC in the near future to review the PET standards. Do you have any questions?

MS. TURNER-BAILEY: Commissioner Sandler?

DR. SANDLER: A topic near and dear to my heart. I'll make a few comments. First PET does not diagnose cancer, except for lung cancer, solitary nodules. What is does is assess the extent of the disease process. A minor point, but --

MS. BOSSCHER: Okay.

DR. SANDLER: Two, I'm still confused about what you want, however. You want something for relocation -- Spectrum, St. Mary's, is thinking of relocating their PET scanner?

MS. BOSSCHER: This joint venture that we have formed has been extremely successful. And in the future, there could be a need for more than one PET scanner in the Grand Rapids area. And all we would ask is that there would be a provision in the standards to relocate, you know, one to each of the locations. It's not -- you know, no specifics, but just so that it can -- it can be even a possibility because right now there are -- there are not possibilities.

DR. SANDLER: Well, okay. However, I think the issue you're looking at is the issue that was raised by Mr. Meeker the last time he was here and has been raised by at least the DMC group of radiologists; that they wish to look at the volume requirements in the standards for obtaining a second scanner.

MS. BOSSCHER: And that can be addressed. We just would urge that the issue of relocation also be addressed. Because right now, there are provisions in the standards for acquiring or getting a second scanner. But there are no requirements or any kind of standard -- anything in the standards that addresses relocating a second machine.

DR. SANDLER: Okay. Thank you.

MS. BOSSCHER: Any other questions?

ALL: (No response)

MS. BOSSCHER: Thank you.

MS. TURNER-BAILEY: Thank you. Amy Barkholz and Larry Horowitz? (Off the record interruption)

MS. BARKHOLZ: I would just like to say to the outgoing members and outgoing chair that on behalf of the hospitals and the MHA, it's been a pleasure to work with both of you, and I've always appreciated your willingness to listen to the issues that I've raised. I know you haven't always agreed with me, but it's been a pleasure to work with you. So thank you very much for your service.

MS. TURNER-BAILEY: Well, thank you.

MR. HOROWITZ: And as the second part of this dynamic duo, I think -- we thought it would be a good way of demonstrating the broad-based perception of this. And I think I can only speak for purchasers in hospitals, but

I'm think I'm confident in saying we speak for the doctors and the physical therapists and all the different groups that have come before this Commission and certainly want to express our appreciation to Renee, who's been an outstanding chairperson and a hard-working chairperson for this three years and is heroic enough to be willing to serve out her remaining term on the Commission. And thanks to Commissioner Delaney for his continued service, even filling in when the Governor hadn't gotten around to naming a replacement. So thank you both very much. It's -- without this kind of volunteer involvement and engagement, the program would not work as well. Thank you.

MS. TURNER-BAILEY: Thank you. That's very nice. (Off the record interruption)

MS. TURNER-BAILEY: I will accept a motion on the work plan at this time.

MR. GOLDMAN: Move to approve.

DR. AJLUNI: Support.

MS. TURNER-BAILEY: Commissioner Goldman moved to approve and Commissioner Ajluni supports. And this is with the -- all the changes that Brenda read today. Discussion?

ALL: (No response)

MS. TURNER-BAILEY: All those in favor, please signify by raising your right hand.

ALL: (Affirmative response)

MS. TURNER-BAILEY: Approved unanimously. Thank you. Brenda?

MS. ROGERS: This is still kind of tied to the work plan. Separate issue, but still kind of tied. In your packet you should have a schedule for updating the standards every three years. That is on the end date under the statute. What we attempted to do was to set up a time line so we're not looking at the full set of 15 or however many standards there are, all in one year. So this is a proposal. We've already deviated, but it's a proposal. I will just quickly go through this. And if you want to think about this and talk about it at your next meeting, that's fine. What we attempted to do was you'd have about five standards each year that you would be looking at. In January of each year, starting with 2006, we would hold a public hearing for those standards that are up for review for that particular year. If -- and depending on what the testimony that we receive, if it looks like there needs to be changes to a particular set of standards, then it would come back to the Commission, and then from there it would go either -- the Commission could delegate it to a SAC, workgroup, department, et cetera. If a standard had no comment or it doesn't look like there's any changes, well then you've got a major obligation to take a look at that set of standards. So that's our thought behind this. 2005, we originally thought, because there were already standards on your work plan in the process -- okay? -- So the thought was to have cardiac cath, hospital beds, MRT, open-heart surgery, PET and surgical services for the review for this year. For 2006, it would be bone marrow transplant; heart, lung and liver transplant, MRI, pancreas, psych beds. And then in 2007 would be the remaining standards: Air ambulance, CT, NICU, nursing home, and lithotripsy. So we tried to group them, realizing that some standards constantly have activity. So we tried to spread those out. So that's the thought process behind this. If you have any questions, feel free to ask. And, again, if you don't want to take any action with this today, you want to bring it back to your next meeting to think about, that's fine.

MS. TURNER-BAILEY: What do we need to do with it? Can we just say, sure, go ahead? Or do we take a vote on it or anything?

MS. ROGERS: If it's something you want us to formally -- if the Commission wants to formally adopt and start using in the process to update these standards every year, to be more official, I think that would be helpful if you have a formal motion.

MS. TURNER-BAILEY: What happens if we do that and then, as you mentioned, there's a deviation?

MS. ROGERS: There are going to be times where there's a deviation. And I guess that's where the Commission is going to have to decide. You know, when somebody brings an issue before you, is it something that truly needs to be changed right now, or if that set of standards is up for review, let's say, next year, can it wait until then? I mean, that's going to be a call that the Commission's going to have to make.

MS. TURNER-BAILEY: Okay.

MS. HAGENOW: I would vote -- I mean, I would make a motion that we adopt the schedule that you've set so that we don't go lower than that. In other words, there maybe more often activity but that we take these on the schedule --

MS. DEREMO: As a minimum.

MS. HAGENOW: -- as a minimum.

MS. TURNER-BAILEY: Okay. There's a motion on the floor. Is there support?

MS. DEREMO: Support.

MS. TURNER-BAILEY: Okay. Commissioner support -- Commissioner Hagenow moved and Commissioner Deremo supported that we accept the schedule for updating the CON standards every three years as presented by the Department with the understanding there may be activity more often than this, but certainly with the thought that we wouldn't slip less often than this. Any discussion?

MR. MAITLAND: Are we going to have this as a supplement to the work plan, so we review this at every meeting? Is that your intent?

MS. ROGERS: Yeah; that is my intent. I've talked to Chairperson Turner-Bailey. What will happen at this point in time is this will be attached to the work plan as a supplement. And then I am going to attempt, as I get some time here, to incorporated it onto the work plan, and then hopefully maybe revise this current work play, the layout. But in the meantime, it will be attached as a supplement to the work plan.

MS. TURNER-BAILEY: Any other questions?

ALL: (No response)

MS. TURNER-BAILEY: Any further discussion?

ALL: (No response)

MS. TURNER-BAILEY: All those in favor, please signify by raising your right hand.

ALL: (Affirmative response)

MS. TURNER-BAILEY: Opposed?

ALL: (No response)

MS. TURNER-BAILEY: Okay. It's unanimous. Term expirations.

MS. ROGERS: Just wanted to bring some reminders to the commissioners as far as expirations of the appointments. We have Dr. Ajluni's term expires April 9th, 2005; Commissioner Delaney, as you all know, his term expired January 1st, 2005; and then we have Commissioner Young, whose appointment also expires April 9th, 2005. Just keeping in mind you can continue to serve until either reappointed or replaced. But just wanted to let people know where we're at with expirations.

MS. TURNER-BAILEY: Okay. Any questions?

ALL: (No response)

MS. TURNER-BAILEY: In that case, a motion for adjournment would be in order.

MS. HAGENOW: So moved.

MS. TURNER-BAILEY: Moved --

MR. DELANEY: Support.

MS. TURNER-BAILEY: -- supported that we adjourn. All those in favor?

ALL: (Affirmative response)

MS. TURNER-BAILEY: We're adjourned at 2:55. (Meeting adjourned at approximately 2:55 p.m.)